THE MANAGED CARE ANSWER GUIDE

- Understanding Managed Care Terminology
- A Consumer Guide to Selecting an Insurance Plan
- Understanding the Provisions of Your Plan

PAF Patient Advocate Foundation

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TABLE OF CONTENTS

INTRODUCTION

The *Managed Care Answer Guide* is designed to help people make decisions about choosing a health care plan. This guide is also designed to assist consumers in understanding parts of their health care plan that may be confusing once they have made health insurance choices.

Finally, a section is included for those people who are insured and find out they have cancer or another chronic, debilitating disease. This section helps explain what questions to ask of their current health insurance company.

There are three parts in the *Managed Care Answer Guide*:

- **PART I** entitled Understanding Managed Care Terminology: A Reference Manual, is a dictionary of selected health insurance and medical terms to aid those searching for a health plan and for reference after choosing a plan.

- **PART II** entitled A Consumer Guide to Selecting an Insurance Plan, deals with questions to be asked before choosing a plan and may help people make an informed decision. Selected criteria to use in evaluating plans are included in this section.

- **PART III** entitled Understanding the Provisions of Your Plan, assists people after they find out they have a serious medical condition. Certain problems prompt some common questions to ask the insurance company.

Purchasing a health care plan is a major decision and usually an expensive one. Consumers must be well informed in order to choose a health plan that is best for themselves and their families. Conduct thorough research and choose a health insurance plan that offers the most comprehensive coverage, making sure to consider any existing personal health needs that you may have.

It is our hope that this publication will serve as an educational resource and reference guide to those in need of specific answers and general information about the complicated and ever-changing world of managed health care. However, this should not substitute for an in-depth discussion about your specific concerns with a healthcare insurance specialist.

PART I: UNDERSTANDING MANAGED CARE TERMINOLOGY

Understanding Managed Care Terminology: A Reference Manual begins with a general description of managed care including various payment methods and types of managed care organizations. Detailed definitions of managed care terms follow. Acronyms, abbreviations, and terms used in the managed care insurance business are defined according to current usage and common meaning. The glossary covers the general to the specific within managed care. Some terms may have a different meaning in the health insurance arena or are unique to the health care field. Keep in mind that definitions may be used to preclude or exclude specific plan benefits or services. It is wise to obtain and study your health plan document.

DESCRIPTION OF MANAGED CARE

Managed care is the prevalent system through which health care services are coordinated and delivered today. This system provides a broad range of health insurance products available to consumers. Managed care integrates the payment and delivery of health care products and services to consumers in an effort to deliver the highest quality services at the lowest possible cost.

Hospitals, physicians, laboratories, and clinics comprise the managed care provider organization. “Center of Excellence” is a designation assigned by managed care organizations to indicate hospitals or networks of hospitals that have been selected to provide patients with a specific set of clinical services, such as transplants, as part of the participating provider network. Hospitals designated as Centers of Excellence may be chosen because they meet the criteria developed by the plan including quality of care goals and/or competitively priced services. Centers of Excellence require board certified physicians to operate their programs and include regular reviews of the provider hospitals’ performance status. These centers require that specific credentialing criteria be met by both the hospital, its support services such as the laboratory and/or pharmacy, and its personnel. In order to maintain the Center of Excellence designation the managed care representatives conduct periodic re-examinations of the facility, programs and personnel.

The managed care system of health care delivery is a change from the indemnity plans that were the primary health insurance plans in this nation prior to the emergence of managed care plans. The indemnity plan requires the plan member to prepay a premium in exchange for a specific amount of monetary coverage in the event of illness or accident.

Fee-for-service is a form of reimbursement based on specific services provided to the plan member. This is a singular reimbursement system within the global world of managed care. In this system, the physician or other suppliers of service will be paid a specific amount for specific services rendered as defined in the fee-for-service plan. This plan may result in the patient being billed for the difference between the billed charges amount and the fee-for-service amount paid to the provider by the managed care plan.

MANAGED CARE ORGANIZATIONS

Providers of care, such as hospitals, physicians, laboratories, clinics, etc., comprise a “managed care organization” delivery system often known as an “MCO.” Seven common MCO models are:

1. ***Health Maintenance Organization (HMO)*** HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals, and other health professionals. Members are required to choose a primary care physician (PCP). A beneficiary must obtain referrals from their PCP for services rendered and must also utilize participating or “in-network” providers. Reimbursement is rendered only when a member obtains appropriate pre-authorization for necessary services and /or receives care by a participating provider.

2. ***Preferred Provider Organization (PPO)*** Also referred to as an “open-ended” HMO, PPO plans encourage but do not require members to choose a primary care provider (PCP). Subscribers choosing not to be treated by a network physician must pay higher deductibles and co-payments than those utilizing network physicians.

3. ***Point-of-Service Plan (POS)*** This type of health plan offers a great deal of flexibility and choice regarding providers and facilities. These plans reimburse at a set percentage regardless of who renders care. Beneficiaries are not required to utilize a primary care physician (PCP).

4. ***Exclusive Provider Organization (EPO)*** A network of providers that have agreed to provide services on a discounted basis. Enrollees typically do not need referrals for services rendered by network providers (including specialists). However, if the patient elects to seek care outside of the network, he or she will not be reimbursed.

√

5. ***Physician-Hospital Organization (PHO)*** A contracted arrangement among physicians and hospitals wherein a single entity, the Physician Hospital Organization, contracts to provide services to insurers' subscribers.

6. ***Individual Practice Association (IPA)*** A formal organization of physicians or other providers through which they may enter into contractual relationships with health plans or employers to provide certain benefits or services.

7. ***Managed Indemnity Program*** A program in which the insurer pays the cost of covered services after services have been rendered and various methods have been used to monitor cost-effectiveness. These methods would include pre-certification, second surgical opinion, case management services, and utilization review. This type of plan is also called a managed fee-for-service program.

COMMON DEFINITIONS FOR TYPES OF MANAGED CARE

Managed Care defines certain types of medical care in order to better "manage" or control the provision and payment of care.

Primary Care includes the diagnosis, treatment and management of general medical conditions. Emphasis is on prevention through immunizations, wellness check-ups, screening services and education of patients. It is usually provided by family practice doctors, internists or general practitioners. The primary care physician focuses on wellness and providing routine care.

Primary Care Physician (PCP) serves as a gatekeeper controlling access to more expensive care or specialty services. This physician is often charged by the managed care plan with making referrals to specialists for plan members who need access to specialty care.

Managed care organization enrollees are assigned to or choose a primary care physician who coordinates and manages all aspects of their medical care.

Specialty Care is care focused on dealing with the diagnosis and treatment of specific, non-routine conditions. Medical services are received from specialists or physicians with additional training and education in a particular field of medicine such as cardiology, surgery, oncology or orthopedics.

Acute Care refers to the intensive services provided in a hospital setting or outpatient care facility, for serious or complex conditions.

Emergency Care refers to intensive services given in an emergency room or emergency care center. Care is administered to stabilize a patient's medical condition and/or prevent loss of life or worsening of the condition.

Chronic Care refers to non-acute care usually delivered in a nursing home, or out-patient setting such as clinics, or by a home care organization. Care needed is for a long-term duration for chronic, recurring conditions. An example would be skin ulcer therapy in a diabetic patient administered in the home by a licensed nurse.

MANAGED CARE PAYMENT METHODS

Many methods exist to pay for provider services, including discounted fee-for-service charges, and capitation. Listed below are some common terms used in insurance plans to define payment obligations on the part of a patient, provider of services, or the insurance company.

Capitation A payment system in which health care providers (physicians, hospitals, pharmacists, etc.) receive a fixed payment per member per month (or year), regardless of how many or few services the patient uses.

Coinsurance An insurance policy provision under which both the insured person and the insurer share the covered charges in a specified ratio (e.g., 80% by the insurer and 20% by the enrollee).

Co-payment A cost-sharing arrangement in which the managed care enrollee pays a specified flat amount for a specific service (such as $15.00 for an office visit or $10.00 for each prescription drug). It does not vary with the cost of the service, unlike coinsurance which is based on some percentage of charges.

Deductibles Amounts required to be paid by the insured under a health insurance contract before benefits become payable.

Discounted Fee-For-Service An agreed-upon rate for service between the provider and payer that is usually less than the provider's full fee. This may be a fixed amount per service or a percentage discount. Providers generally accept such contracts because they represent a means of increasing their volume or reducing their chances of losing volume.

Fee-for-Service (FFS) Reimbursement Payment in specific amounts for specific services rendered. Payment may be made by an insurance company, the patient, or a government program such as Medicare or Medicaid. The form of payment is in contrast to payment retainer, salary, or other contract arrangements (to Physicians or other suppliers of service); and premium payment or membership fee for insurance coverage (by the patient).

Out-of-Pocket Expense The amount not reimbursed by insurance coverage and paid by the patient such as co-payments, deductibles and premiums.

Pharmacy Benefit Coverage of prescription drugs by an insurance company. Often, beneficiaries will have an identification card designating their eligibility and will have to pay partially for the drug in the form of co-payments, deductibles, or coinsurance. Also referred to as a "Prescription Drug Benefit." This benefit may be offered through a company other than your health insurer.

Premium The amount paid to an insurer for providing coverage, typically paid on a periodic basis (monthly, quarterly, etc.).

Prevailing Charge This is a fee based on the customary charges for covered medical insurance services. In Medicare payments for services or items, it is the maximum approved charge allowed.

Reasonable Charge A methodology used by Medicare to determine reimbursement for items or services not yet covered under any fee schedule. Reasonable charges are usually determined by the lowest of the actual charge, the prevailing charge in the locality, the physician's customary charge, or the carrier's usual payment for comparable services.

Reasonable Cost A methodology used by Medicare to determine reimbursement for items and services that takes into account both direct and indirect costs of providers such as hospitals, as well as certain Medicare HMOs and competitive Medical Plans.

Reimbursement Reimbursement Refers to the actual payments received by providers or patients for benefits covered under an insurance plan.

Third-Party Payment (a) Payment by a financial agent such as an HMO, insurance company, or government rather than direct payment by the patient for medical-care services. (b) The payment for health care when the beneficiary is not making payment, in whole or in part, on his/her own behalf.

Usual, Customary, and Reasonable (UCR) Charges Private health insurance offers the basis for reasonable-charge reimbursement of physicians. This approach was developed before the introduction of Medicare and was adopted by Medicare. "Usual" refers to the individual physician's fee profile, equivalent to Medicare's "Customary" charge screen. "Customary," in this context, refers to a percentile of the pattern of charges made by physicians in a given locality. "Reasonable" is the lesser of the usual or customary screens.

SPECIFIC FEATURES OF HEALTH MAINTENANCE ORGANIZATIONS (HMO)

A cost management feature of the HMO is procurement of approved contracted member providers, including physicians, specialists, hospitals, clinics and laboratories. HMOs are financed by fixed periodic payments determined in advance by contractual agreement between the insurance company (the HMO) and the employer contracting to buy services for their employees.

An "HMO" also may be referred to as a "pre-paid health plan," as the HMO combines two functions:

- It provides health coverage to its enrolled members and,
- It provides them comprehensive health care services through a pre-approved network of physicians and healthcare service entities.

The HMO concept is different than the traditional private "fee-for-service" model, in which providers charge a fee for each service or procedure provided to the patient. The HMO identifies one fixed fee per service required. Enrollees must utilize the pre-approved provider so members receive payment for healthcare services from the HMO. One of the universal concerns voiced by members within HMOs is their loss of freedom to choose their healthcare providers and services. In an effort to control costs, HMO organizations must confine access to those providers who agree to accept the pre-contracted fees for services.

Health Maintenance Organizations may be publicly owned for-profit organizations or non-profit, private, independent companies. Some are affiliates of large insurance or managed care companies. Some are small regional organizations. The degree of control exerted, the service area the HMO covers, financial stability, and profit status, either for profit or non profit is important to know when selecting a plan to determine the HMOs stability in the market and know their service area.

HMOs are regulated by both the federal government and by most states through the Department of Health or Department of Insurance. Regulations emphasize access to care, patient protection and financial status (i.e., stability and profit or non-profit status of the HMO).

HMO ORGANIZATIONAL MODELS

There are several common models of HMOs, differing only in the relationships of the providers to the organization that is the HMO.

Staff Model The Health Maintenance Organization employs the physician, and care is usually provided in a facility owned by the HMO. There is a high degree of control over care delivered, and thus premium costs are often lower in this type of structure due to the HMO's ownership of the facility.

Group Model This type of HMO plan is structured around a multi-specialty medical group that may include internists, obstetricians, gynecologists, cardiac and oncology specialists and surgeons contracting exclusively with the HMO to provide services. Care is delivered in facilities owned either by the physician groups, such as clinics, or the HMO, such as a hospital.

Network Model This model is an HMO that contracts with many IPAs and other provider groups to form a "physician network." Care can be provided in a larger geographic service area than would be possible with only one physician group. This network model offers the patient choice of physicians and managed costs.

Mixed Model This term describes certain HMO plans in which the provider network is a combination of delivery systems. In general, a network, or mixed model HMO, offers the widest variety of choices and the broadest geographic coverage to its members. Patients will often have a choice of clinics, labs, pharmacies, and hospitals as their providers of care.

GLOSSARY OF MANAGED CARE DEFINITIONS

A

Accreditation: a systematic review of a managed care plan by one of three private, non-profit agencies (the National Committee for Quality Assurance, the Joint Commission on the Accreditation of Health Care Organizations, and the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission). The review assesses how the plan compares to standards developed by each organization in specific areas, such as credentialing of health care providers, quality assurance programs, consumer satisfaction, etc. Plans that meet standards receive a stamp of approval called accreditation. Maintaining accreditation requires undergoing review on a periodic basis.

Actual charge: the price levied by a health care provider (for example, a hospital or physician) on a consumer or a managed care plan, for a specific medical product or service.

Actuarial: methods and calculations used to estimate the financial risk for a managed care plan of enrolling a specific consumer or group of consumers. Based on these calculations, the insurer develops eligibility criteria, as well as premiums that it will charge the consumer(s).

Acute care: short-term treatment for an illness that is limited in its duration. Examples of acute care include a physician office visit to suture a wound or hospitalization for a heart attack. The goal of acute care is to cure the illness or prevent worsening.

Acute illness: an ailment (illness or injury) that is limited in its duration and resolves before becoming chronic and requiring on-going management. Acute illnesses range from the common cold to food poisoning to heart attacks.

Administrative costs: expenses related to running an organization, such as overhead (rent, utilities, and supplies), advertising and marketing.

Adverse selection: a situation in which a managed care plan's population of consumers is older or sicker than expected and, consequently, more likely to incur higher expenses for the plan.

Allowable charge: amount that a managed care plan determines is the appropriate amount to pay a health care provider for a specific product or service. The allowable charge is frequently lower than a health care provider's actual charge.

Alternative health care: amount that a managed care plan determines is the appropriate amount to pay a health care provider for a specific product or service. The allowable charge is frequently lower than a health care provider's actual charge.

Ancillary services: : imaging (such as x-rays and CAT scans) and laboratory testing (such as blood or urine testing) that are provided to a consumer in conjunction with hospital or physician care to assist with diagnosis and treatment.

Any willing provider: laws that require managed care plans, such as health maintenance organizations, to contract with all physicians or hospitals in the area served by the plan who wish to serve the plan's members.

Appeal: review of an adverse coverage decision by a managed care plan. Appeals are typically initiated by consumers or their physicians when they and the plan disagree with a plan's decision to deny or limit care.

Assignment: process by which a health care provider, such as a physician, agrees to accept payment for a product or service directly from the managed care plan. Assignment typically also limits the amount the health care provider can collect from the consumer, in addition to the allowable charge, as determined by the managed care plan. (See balance billing below.)

At-risk: a situation that occurs when a health care provider receives a fixed, predetermined sum of money to care for a consumer (or group of consumers) and stands to lose money if total expenses for care exceed the amount paid.

Authorization: approval by a managed care plan for a consumer to receive a health care product or service, such as a specific medical treatment, surgical procedure, or diagnostic test.

B

Balance billing: a system in which a health care provider can collect from a consumer the difference between the provider's actual charge and the insurer's allowable charge. For example: a provider's actual charge for a service is $100, and the insurer's allowable charge is $80, of which it pays 80 percent ($64). In balance billing, the provider can collect $36 from the consumer. A provider who accepts assignment (see above) would only be able to collect $16 from the patient.

Behavioral health care: products and services intended to diagnose and treat mental and emotional illnesses, such as depression or substance abuse.

Beneficiary: a consumer, or his or her dependent, who enrolls with a managed care plan, and is entitled to receive coverage and payment for health care products and services covered by the contract with the plan.

Benefit limits: caps on how much the managed care plan will pay for specific health care products or services, or the quantity of services a consumer may receive (such as the number of visits to specialty physicians).

Benefits package: the set of health care products and services covered by the contract between a managed care plan and the purchaser of care (typically an employer or individual consumer). The benefits package can include items such as hospital and physician care, prescription drugs, diagnostic testing, and other services.

Board certified: describes the level of training and competency testing successfully completed by a physician. A board certified physician has completed medical school, post-medical school training (known as residency), and passed an exam in one of the areas of specialization or sub-specialization recognized by the American Board of Medical Specialties.

Brand-name drug: a drug that carries a specific, trademarked name and is produced by one manufacturer.

C

Capitation: a system managed care plans use to pay physicians or hospitals, in which the providers receive a fixed, predetermined sum of money, typically on a monthly basis, from the plan to care for plan members. Capitation places providers at-risk (see above) for financial losses.

Carve out: a product or service (such as prescription drug benefits or mental health care) provided by a managed care company that specializes in the particular service.

Case management: process managed care plans may use to review the care that patients receive. The goal of case management is to ensure that patients receive the appropriate service from the right provider, at the right time, and in the least costly setting. Case management typically is performed by physicians or nurses who are paid by the plan.

Case rate: a payment system in which the managed care plan pays health care providers an all-inclusive fee to provide care for a patient, based on the patient's diagnosis, or the medical treatments or surgical procedures provided to the patient.

Center of excellence: is a designation assigned by the managed care industry to provide hospitals or a network of hospitals selected to provide managed care plan for patients with a specific set of clinical services, such as transplants. Hospitals designated as centers of excellence may be chosen because they meet criteria developed by the plan, such as quality of care goals and competitively priced services.

Centers for Medicare and Medicaid Services (CMS): a federal agency that runs the Medicare and Medicaid programs.

Chronic care: supportive care for an ongoing or lengthy illness. The care includes diagnosis and treatment of complications and patient education, with the goals of minimizing symptoms, maintaining the

maximum level possible of patient functioning, and preventing a worsening of the patient's ailment.

Chronic illness: any ailment that requires on-going treatment and management, beyond its acute phase, sometimes for a lifetime.

Claims form: paperwork that patients and health care providers file with managed care plans in order to receive payment for services.

Clinical pathway: a medical "roadmap" that helps health care providers identify the most appropriate course of treatment for a specific patient, based on that patient's clinical situation.

Clinical trial: a medical research study in which physicians assess the effect of a new test or treatment versus an existing test or treatment or none at all. Clinical trials typically have four parts or phases. A majority of clinical trials may include the following stages:

A Phase 1 trial is the first test of a new drug and/or therapy in humans. Phase 1 trials are intended to assess the safety of a therapy in humans, usually in a small number of patients. In cancer care, some patients who have not responded to other treatments are enrolled in Phase 1 trials to see how the new drugs work for them.

A Phase 2 trial builds on information gathered in Phase1 and assesses the effectiveness of the therapy in small groups. Treatments that show promise in Phase 2 then move to Phase 3.

A Phase 3 trial compares the new treatment with therapies currently in use to see which one is more effective. Finally, a Phase 4 trial is done after the treatment is approved for patients with a particular diagnosis.

A Phase 4 trial may assess how well the new therapy performs when it is used in combination with other treatments, such as surgery or other drugs. Generally, Phase 4 is used to test effectiveness on larger groups.

Closed panel: a situation in which the physicians who work for a managed care plan see and treat only patients belonging to the plan.

Co-payment: a fixed sum of money that a consumer pays each time he or she receives a covered service from a plan contracted provider. For example, in many managed care plans, the co-payment for a physician office visit is $10.00 or $15.00.

Coinsurance: the portion of health care costs not paid by the managed care plan, for which the consumer is responsible. Coinsurance usually is expressed as a fixed proportion of the managed care plan's allowable charge. For example, if a plan pays 80 percent of its allowable charge for a covered service, the consumer is responsible for the remaining 20 percent as coinsurance.

Contract: legal agreement between a managed care plan and either an employer or a consumer that describes the monthly premiums due to the plan, the health care services covered by the plan, and how much the plan is obligated to pay for each service. Contracts are usually renegotiated annually. Managed care companies may also sign contracts with health care providers to care for plan members for negotiated fees.

Contract year: the 12 month period covered by the agreement between the plan and the employer, consumer, or provider.

Contracted provider: a hospital, physician, network of hospitals and physicians, or other healthcare providers who enter into a legal agreement with a managed care plan to care for the plan's members for negotiated prices.

Coordination of benefits: a process that takes place between two or more managed care plans that cover the same consumer, to ensure that plans do not make duplicate or unnecessary payments for services.

Cost sharing: the responsibility of a consumer in a managed care plan to pay a portion of the costs for his or her care. Cost sharing can come in three forms: co-payments, deductibles, and coinsurance.

Cost-based reimbursement: a payment system in which managed care plans pay health care providers based on the actual cost of a test or treatment provided to a plan member.

Coverage: decision making process that identifies what services or products are benefits under the employer's or consumer's contract with the plan. Covered products or services are eligible to be paid for by the plan.

Covered Expenses: the costs of health care products or services that are eligible for payment by the managed care plan. Services that are eligible for reimbursement under the provisions of the plan.

Credentialing: a system used by managed care plans to assess the qualifications of physicians or other health care providers who may be offered contracts with the plan.

Customer service: a resource available to the managed care plan member to answer member's questions, help resolve disputes or complaints, and explain plan operations.

D

Deductible: a form of cost sharing in a managed care plan, in which a consumer pays a fixed dollar amount of covered expenses each year, before the plan begins paying its share of costs.

Denial of care: a refusal by a managed care plan to cover a specific test or treatment.

Direct contracting: the legal relationship between a managed care plan and an employer, in which the managed care plan agrees to provide a specific set of health care benefits for employees, for specified premiums.

Discounted fee-for-service: a payment system in which a managed care plan pays a health care provider a negotiated fee for each specific health care service, after the service is rendered to a plan member. The payment is usually a proportion of the provider's actual charge for a product or service.

Disease management: an organized, integrated program of health care and patient education aimed at providers or patients with a specific diagnosis, such as cancer or diabetes. The goals of disease management are to improve care, lower costs, and measure patient outcomes or satisfaction with care.

Drug formulary: an exclusive list of drugs covered by a managed care plan.

Drug utilization review: systematic oversight of prescription medicines used by managed care plans to assess costs, prescription patterns, and the appropriateness of drug therapy.

E

Emergency care: urgent medical tests and treatment provided to patients with severe or life-threatening symptoms.

Employer group health plan: package of medical benefits offered to all the employees at a company, typically using one or more managed care plans.

ERISA (Employee Retirement Income Security Act): a federal law that regulates the pension, health and welfare benefits offered by employers to their employees. Under ERISA, some employer group health plans are exempt from state laws and regulation that govern insurance.

Evidence of coverage: a detailed description of the medical benefits available to a member of a managed care plan, most often provided to members after they enroll in the plan.

Exclusion: a health care product or service that is not eligible for reimbursement under the provisions of the plan.

Explanation of Benefits (EOB): a statement sent to some managed care plan members from the plan that shows the following information: the actual charges levied by a health care provider for health care services provided to the plan member, the plan's allowable charge for each service, the plan's payment for each service, and the amount owed by the plan member (coinsurance or deductible).

F

Fee schedule: a predetermined list of prices a managed care plan will pay for specific health care products or services given to plan members by health care providers.

Fee-for-service payment: reimbursement made by a managed care plan to a health care provider after the provider renders care to a plan member.

First dollar coverage: managed care plan benefits that do not require plan members to meet an annual deductible before plan coverage and payment begin.

G

Gag rules: portions of contracts between managed care plans and physicians that may limit the communication between physicians and their patients. Gag rules may be intended to restrict what physicians may tell patients about the range of testing or treatment options available to them through the plan or the financial relationship between the physician and the plan.

Gatekeeper: a primary care physician who controls a patient's access to certain tests, treatments, and specialty physicians in a managed care plan.

Generic drug: a medicine that is the chemical equivalent of a brand-name drug. Generic drugs are typically less costly to consumers than equivalent brand-name drugs.

Grievance: a complaint brought to the administration of a managed care plan by a plan member. The complaint may pertain to quality of care issues, a plan coverage decision, or financial issues, such as a dispute between the plan and the member over how much the plan has paid for a particular health care product or service.

Group model health maintenance organization (HMO): a type of managed care plan in which the plan has contracted with a multi-specialty physician group to care for plan members. The physicians who treat plan members are employed by the physician group.

H

Health Care Financing Administration (HCFA): See Centers for Medicare and Medicaid Services (CMS).

Health care spending account: a benefit option offered by some employers that lets employees set aside a specific sum of money each year to pay for certain medical expenses, such as premiums, co-payments, deductibles, and coinsurance amounts, or services such as eyeglasses or dental care. Money not spent in any given year generally cannot be returned to the employee.

Health education: programs or classes offered by some managed care plans to their members to help plan members enhance their understanding of specific issues, such as nutrition or contraception, or meet personal goals, such as smoking cessation, weight loss, or stress management.

Health insurance purchasing cooperative: a mechanism in which individuals and small businesses join together to purchase medical benefits from managed care plans. By forming a larger group than they would constitute as individual entities, the employers try to get a lower price from managed care plans for a specific set of benefits.

Health Plan Employer Data Information Set (HEDIS): a set of managed care plan performance measures collected, organized, and reported by the National Committee for Quality Assurance (NCQA, see below).

Hospice care: supportive services provided to patients who have reached the terminal stage of their illness when aggressive, curative therapy is no longer appropriate. Hospice care includes medical services such as pain management, as well as emotional support (for example, counseling) for both patients and their families.

Hospitalist: a physician specialized in inpatient medicine who acts as the patient's primary doctor while they are hospitalized ensuring that tests are evaluated in a more timely manner than possible for private physicians.

Hospital privileges: permission granted by a hospital to a physician to admit patients to the institution and manage their care while hospitalized.

I

Indemnity insurance plan: type of health insurance that pays for care after consumers receive it, usually on a fee-for-service basis, with little oversight to assess the cost or appropriateness of care.

Independent Practice Association (IPA): a type of managed care plan which contracts with many physicians or physicians groups in an area to provide care to plan members.

J

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO): a private, non-profit agency that evaluates and accredits managed care plans, hospitals, networks of health care providers, and other health care entities.

L

Lifetime cap: maximum dollar amount of benefits available to a consumer in a managed care plan.

M

Major medical: health insurance benefits found most commonly in indemnity insurance plans that provide coverage and payment for services such as hospitalization, surgery, or durable medical equipment.

Malpractice: negligent care provided to a patient by a health care provider or managed care plan that results in harm to the patient.

Managed care: a broad term that describes the health insurance products available to most consumers in the health care marketplace today. Managed care more tightly integrates the payment and delivery of health care products and services to consumers to, ideally, deliver the highest quality services at the lowest possible cost.

Managed indemnity insurance: an indemnity insurance plan that incorporates some managed care features, such as utilization review, to help control costs.

Mandated benefits: products or services offered in managed care plans that are required by either federal or state law.

Medicaid: a joint federal and state program that provides health insurance to low income persons who meet specific eligibility requirements.

Medicaid HMO: a managed care plan approved by a state government to enroll persons eligible for Medicaid.

Medical director: the chief physician in a managed care plan who is part of the plan's administration, and oversees plan coverage decisions and the performance of the physicians who work for the plan or sign contracts to serve plan members.

Medical licensing board: a state regulatory agency that authorizes physicians to practice in a state and disciplines physicians who are found to have violated the state's laws or regulations that govern the practice of medicine.

Medical loss ratio: the amount of money spent on medical care for plan members by a managed care plan. Methods of calculating medical loss ratios vary across plans.

Medical record: the official documentation of the care provided to a patient by a health care provider. The medical record includes notes from physician visits, hospitalization records, test results, and consultations by specialists. Each health care provider who treats a patient creates and maintains a medical record on the patient.

Medical underwriting: the process by which a managed care plan evaluates the level of risk posed by an individual consumer or group of consumers, based upon age, sex, health history, or other factors. The plan uses medical underwriting to determine what premium it will charge the consumer(s).

Medically necessary: Medical services or supplies that are considered appropriate care and are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, mental disorders or well-child care.

Medicare: a federal health insurance program that provides medical benefits to all persons over age 65 who receive Social Security benefits or are disabled and meet specific eligibility requirements. Medicare has three parts: **Part A**, which provides coverage and payment for hospital care, **Part B**, which covers physician services and **Part D**, which subsidizes the cost of prescription drugs.

Medicare HMO: a managed care plan that meets federal standards and is eligible to enroll persons who receive Medicare benefits.

Medicare secondary payer: a circumstance in which a Medicare beneficiary has both Medicare and private insurance. Medicare pays for the portion of covered health care services that are not paid by the beneficiary's private insurance.

Medigap: Medicare supplemental health insurance that pays for some of the deductibles and coinsurance for which Medicare beneficiaries are responsible. Medigap insurance plans also may cover some additional services not covered by Medicare, such as prescription drugs. Medicare beneficiaries who desire Medigap insurance must purchase it themselves and pay a monthly premium for it.

Mental health care: : medical services, such as counseling or therapy, hospitalization, and prescription drugs, used to diagnose and treat emotional and psychological illness, such as depression, bipolar disorder, or substance abuse.

Mixed model or network HMO: a managed care plan that contracts with individual physicians, as well as physicians groups to provide care for plan members.

Monthly premium: the amount paid each month to a managed care plan by an employer, employees, or individual consumers to obtain coverage from the plan.

Morbidity rates: the frequency with which an illness occurs in a given population. Morbidity is usually expressed as the number of illnesses per 100,000 population.

Mortality rates: the frequency of death from a given cause in a population. Mortality is usually expressed at the number of deaths per 100,000 population.

N

National Committee for Quality Assurance (NCQA): a private, nonprofit organization that evaluates and accredits managed care plans. The NCQA also gathers and reports managed care plan performance data through its Health Plan Employer Data Information Set (HEDIS) reports.

Networks of health care providers: groups of hospitals, physicians, and other providers that come together to offer managed care plans and consumers an organized, comprehensive system of care.

O

Ombudsman: a troubleshooter who can help managed care plan members resolve problems or complaints with the plan. The ombudsman may work for the plan or for an outside agency, such as a state or county government.

Open enrollment: a specific period of time (one or more times annually or monthly) during which consumers can select and enroll in, or disenroll from, a managed care plan.

Open panel: a situation in which physicians care for patients from many different managed care plans, as well as other insurers, such as Medicaid and Medicare.

Out-of-pocket expenses: costs of health care products or services which managed care plan members pay themselves. Out-of-pocket costs include co-payments, coinsurance, and deductibles. Consumers also may incur out-of-pocket costs for some products or services not covered by their managed care plan, such as over-the-counter drugs.

Outcome data: information that describes the result of care provided to managed care plan members. Outcome data helps identify what tests and treatments have the greatest beneficial impact on patients, as well as the complications and problems that result from them.

P

Participating provider: a hospital or physician who signs a contract with a managed care plan and agrees to care for plan members for negotiated fees and conditions specified in the contract. Typically, when plan members see participating providers, they have low co-payments and no paperwork to file with the plan.

Payer: another term for an insurer that covers and pays for a specific set of health care benefits for plan members.

Per member per month: refers to the incremental sum paid by a managed care plan to a health care provider who cares for plan members under a capitation arrangement. This term also is applied to the premiums paid to managed care plans by employers or to the way Medicare pays Medicare HMOs that enroll and care for Medicare beneficiaries.

Pharmacy and therapeutics committee: a group of physicians, pharmacists, and other health care professionals within a managed care plan who review new drugs and biotechnology products to decide which ones the plan will cover, under what circumstances, and at what cost to the plan and its members.

Pharmacy Benefit Manager (PBM): a type of managed care plan that specializes in the distribution and management of prescription drugs for plan members.

Physician Hospital Organization (PHO): an entity formed by physicians and hospitals under the authority of state or federal law to negotiate and sign contracts with managed care plans or contract directly with employers to serve the health care needs of their employees.

Plan member: a consumer or his or her dependent who enrolls in a managed care plan through an employer, the Medicare or Medicaid programs, or as an individual enrollee.

Point of Service (POS): This type of plan offers a great deal of flexibility and choice regarding providers and facilities. These plans reimburse at a set percentage regardless of who renders care. Recipients are not required to utilize a primary care physician.

Practice guidelines: suggestions or mandates for how physicians can manage patients with a particular symptom or diagnosis to achieve the best possible outcome.

Practice profiling: also known as practice evaluation; the process by which managed care plans measure how well physicians who treat plan members are performing against plan-developed financial and clinical criteria. The practice profiles may affect the physician's compensation by the plan or the plan's decision about whether to sign the physician to a contract in the next year.

Pre-existing condition: a medical condition, ailment, or disease for which a managed care plan member was treated during a specific period of time before joining the plan, typically one or two years. If a consumer has a condition that was treated during this time, the managed care plan, depending on applicable laws and the terms of the contract, may limit how much care it will cover and pay for related to the preexisting condition.

Preadmission certification: prior approval by a managed care plan to admit a member to hospital for medical treatment, testing, or surgery.

Preauthorization: prior approval by a managed care plan for a plan member to receive a medical treatment, test, or surgical procedure on an outpatient basis.

Preferred Drug List (PDL): a list of approved pharmaceutical agents for specified diagnoses.

Preferred Provider Organization (PPO): Also referred to as an "open-ended" HMO, PPO plans encourage but do not require members to choose a primary care provider (PCP). Subscribers choosing not to use a network provider must pay higher deductibles and co-payments than those utilizing network providers; in addition, they may incur additional out of pocket expenses for charges above the Usual Customary and Reasonable charges allowed by the payor.

Premature hospital discharge: termination of an inpatient hospital stay before it is medically appropriate to send the patient home.

Preventive health care: health care products and services aimed at forestalling the development of illness or injury. An example of preventive health care is immunizations to prevent childhood illnesses.

Primary Care Physicians (PCPs): a class of physicians that typically includes internists, family physicians, pediatricians, and obstetricians/gynecologists. As PCPs, these physicians may control access that managed care plan members have to other plan services such as diagnostic testing or visits to specialists.

Provider: a qualified, licensed professional (physician, dentist, optometrist, etc.) or institution (hospital, clinic, skilled nursing facility, etc.) that renders health care services to managed care plan members under a contract with a plan.

Q

Quality assurance: an oversight program used by health care providers and managed care plans to evaluate the care provided to plan members and identify and rectify problems in care delivery.

R

Referral: authorization by a managed care plan or primary care physician for a plan member to use other services in the plan, such as diagnostic tests, care from a specialist, or physical therapy.

Report card: information on how well a managed care plan performs compared to other managed care plans, or national standards, along specific clinical, financial, or consumer satisfaction criteria. Report cards can be developed by plans themselves, private agencies such as the National Committee for Quality Assurance, employers, or government agencies.

S

Screening tests: health care services intended to identify diseases at an early stage of development when they are typically easier and less costly to treat. An example of a screening test is mammography to detect breast cancer.

Secondary payer: a second plan a consumer has. Through coordination of benefits, the second plan will pay for covered services that are not covered and paid for by the first plan.

Shared financial risk: a concept in which health care providers, through payment arrangements with managed care plans such as capitation, share risk on the health care services they provide to managed care plan members.

Specialist: a physician who has received extensive training (beyond that of a primary care physician) in a specific, often highly focused area of medicine.

Staff model HMO: a type of managed care plan in which physicians who care for plan members are employees of the plan.

State insurance commissioner: a regulatory official who enforces the state insurance laws and regulations to which managed care plans are subject.

Stop loss insurance: a type of back-up insurance that limits financial risk for physicians or hospitals who accept capitation payments to care for managed care plan members. Once expenses for a patient reach a specific point, the stop-loss insurance program starts paying bills to limit further financial losses for the capitated provider.

Symptom: manifestation of a disease or illness that a patient expresses to a physician or other health care provider, such as pain, nausea, or dizziness.

T

Technology assessment: process that managed care plans use to evaluate new tests, treatments, drugs, medical devices, biotechnology products, and surgical procedures, to decide what the plan will cover, for which patients, and at what costs to the plan and plan members.

Therapeutic substitution: replacement of a drug prescribed by a physician with a similar or equivalent product, usually with permission of the prescribing physician.

Third-Party Administrator (TPA): a managed care plan or other health insurer that processes claims, pays bills, and manages contracts with health care providers for self-insured health plans.

Triage: a system by which managed care plans or health care providers prioritize patients to ensure that patients with the greatest need receive care first.

U

Usual, customary and reasonable charges (UCR): a calculation by a managed care plan of what it believes is the appropriate fee to pay for a specific health care product or service, in the geographic area in which the plan operates.

Utilization review: a mechanism of assessing the care received by a patient in a managed care plan to assess whether the care is medically necessary and appropriate to the patient's needs.

W

Withhold: a portion of the fees paid to health care providers by managed care plans that are held back by the plan until the end of the contract year. Then, if the provider meets specific plan criteria (see practice profiling), the plan may pay the held back money to the provider in the form of a bonus.

PART II: A CONSUMER GUIDE TO SELECTING AN INSURANCE PLAN

Many factors should be considered before choosing a health insurance plan. Buying insurance is a very important decision, and it is essential to have as much information as possible before a particular plan is chosen.

An inventory of your particular health needs is an important tool in choosing a health insurance plan. Your family's personal health history should serve as a basis for determining services you will want your plan to include. For example, if you have a child with allergies you will want to ensure that your plan provides adequate coverage for specialist visits and treatment. You would also want to carefully evaluate maintenance medications necessary for the treatment of the allergies against the coverage and/or restrictions of the plan's pharmacy benefits. Chronic family disease patterns such as diabetes should be considered when you select coverage benefits.

Written information about the types of plans available and details of each plan should be obtained from either your employer, benefits manager for your company, or directly from your plan. The insurance company may provide a handbook that describes your benefits. If you need further clarification or have questions about your benefits, call either the employer's benefits manager or the member services department of the insurance company. **Get answers in writing**. Ask for toll-free telephone numbers for the insurance company. If you have a choice among various types of managed care plans, such as an HMO or PPO, use consistent criteria for comparing plans.

In an effort to control costs, HMOs may offer limited choices and benefits to the insured which may be more restrictive than Preferred Provider Organizations or fee-for-service medicine. On the plus side, HMOs are usually less expensive than PPOs. Keep in mind that all managed care plans are designed to control costs of care and expenditures by the insurance company. Some plans contract with providers at reduced fees for all services. In other plans, enrollees may choose a primary care physician from the list of participating physicians. This doctor, known as the gatekeeper, will authorize diagnostic tests, treatments, hospitalizations, and referral to specialists. Additionally, a plan administrator must approve many services, including hospitalization and length of stay in the hospital. These processes may result in greater savings than a traditional indemnity insurance program. These savings may be passed on to enrollees in the form of lower premiums and out-of-pocket expenses.

Since managed care plans save money by aggressively controlling the care an enrollee receives, it is critical that adequate factual information be obtained **before** making a decision about what plan to purchase. Services needed and wanted by you and your family should be compared to what the plan makes available. Ultimately, you may choose to pay more for the availability of benefits desired and needed in your particular health plan.

NAVIGATING YOUR PLAN

Understanding your needs at the time you purchase a plan is perhaps the key to avoiding the need for filing a grievance or an appeal. There may be variations in interpretation of benefit language between the plan member and the plan administrator when critical health care issues are at stake. It is important that you have a full copy of your plan language as this is the contract which governs your rights to insurance coverage and/or benefit access. Plan summaries often do not describe benefit entitlements or exclusions in detail.

The following guide may be helpful in understanding how to access the plan you need, the coverage benefits your plan includes and what you need to do if a complaint needs to be filed.

STEP 1 **PRIORITIZE YOUR NEEDS** Make a list of your current and anticipated health care needs. Do you have a chronic illness that requires ongoing care? Are you anticipating having an elective surgical procedure or a pregnancy in the coming year? Do you have children? Are you interested in any specific health education services, such as weight loss or smoking cessation counseling?

STEP 2 **EVALUATE YOUR MANAGED CARE OPTIONS** Assess the managed care plans available to you. Are they accredited? Can you use your current doctors and hospitals, or will you have to choose new ones? Which plans offer special programs that interest you, such as support groups or disease management for patients with cancer? What are the monthly premiums, co-payments and deductibles for each plan? Choose a plan based on your specific needs, plan qualifications and affordability.

STEP 3 **CHOOSE YOUR PRIMARY PHYSICIAN** The plan may require you to select a physician from the plan's network, or it may allow you to continue seeing your current physician at an additional cost in the form of higher co-payments. Seek physicians who are qualified (board certified in the field of medicine you need), compassionate and who communicate well. When you meet with the physician discuss your expectations and preferences for your care. Ask questions about topics that are important to you, such as financial issues or concerns about your care.

STEP 4 **ASSESS YOUR SATISFACTION WITH YOUR PLAN** If you are satisfied with the service provided by your plan, you should consider remaining enrolled. Take time to participate in consumer satisfaction surveys sponsored by your plan or your employer's benefits manager. If you are dissatisfied with your plan, move to step 5.

STEP 5 **ADDRESS YOUR DISSATISFACTION WITH YOUR PLAN** When dissatisfied with your plan, take action! First, file a complaint with the plan. If the plan does not resolve your complaint satisfactorily, then contact the state agencies that oversee managed care plans where you live. These include the state health and insurance departments and attorney general's office. The phone numbers for these agencies are in the state government listings in the phone book. File your complaint in writing, and document events as carefully as possible. Ask your physician(s) to advocate for you and provide the plan and state agencies with medical studies or expert opinion(s) that support your case in a dispute.

STEP 6 RECONSIDER YOUR MANAGED CARE CHOICES When your complaint is resolved, reconsider whether you wish to leave your plan for another, or remain enrolled. Changing plans usually can be done only during open enrollment, which typically occurs annually or monthly. (Ask your employer or the plan to find out for sure.) Provide feedback to your employer about your problems with the plan.

EVALUATING MANAGED CARE PLANS

When faced with a choice of purchasing one insurance plan over another, we caution you to remember the old adage caveat emptor -"Let the buyer beware." This is fitting advice for making any important decision. Thus, in preparation for making your decision and especially during the evaluation process: Read, study, ask questions, and good luck!

The nine helpful criteria we have identified when evaluating a managed care plan are:

A. BENEFITS OFFERED or COVERED SERVICES

B. COST VS. BENEFITS

C. SERVICES OF THE PRIMARY CARE PHYSICIAN

D. PRESCRIPTION DRUG BENEFITS

E. PROVIDER NETWORK AND GEOGRAPHIC SERVICE AREA

F. COMMITMENT TO QUALITY OF CARE AND SERVICE

G. CUSTOMER SATISFACTION

H. LIMITATIONS, MAXIMUMS, or EXCLUSIONS

I. COBRA to include transferability/portability and conversion information

A. BENEFITS OFFERED

Look for a plan that offers a comprehensive benefits package including preventive care as well as treatment programs for chronic disease management. Inquire about emergency care and care away from home. If these services are important to you, be sure to get answers about benefits provided for treatment. Sample questions are:

If hospitalization is limited to a brief stay, does the plan cover post-hospital care, such as home care visits if needed? Early discharge from the hospital may require follow-up care with home visits. A plan for telephone communication, and follow-up education services are essential to ensure that convalescence and recovery are progressing as planned.

What preventive services and programs are available? Managed care plans may help their enrollees to achieve optimal health by offering the following preventive services:

- Well baby immunizations and visits; well child visits
- Screening and early detection for the following:
  - ✔ Breast cancer
  - ✔ Colorectal cancer
  - ✔ Hypertension
  - ✔ Cervical/ovarian cancer
  - ✔ Coronary artery disease
  - ✔ Melanoma
  - ✔ Prostate cancer

What programs help patients with chronic disease?

- The services of a nurse should be available either by telephone, home visit or clinic service 24 hours a day.
- Equipment needs, such as motorized wheelchairs, inhalation therapy machines and I.V. equipment. Determine the coverage benefits for purchase of equipment.
- Find out if a pre-existing chronic condition is covered. If not, question how long denial of coverage for a pre-existing condition will last. If restrictive, ask if a rider for coverage can be purchased and what the rider will cost.
- Ask if your plan provides benefits for hospice care. Hospice care includes medical services such as pain management as well as support such as counseling for both patients and their families.

What about Emergency Care? What, when and where is emergency care covered? Emergency care, while always a covered benefit, can be a problem depending on how the insurance company defines an emergency. There may be benefit differences between a **medical emergency** and a **surgical emergency** or **accidents** requiring emergency or urgent care. Plans are designed to discourage expensive use of high-tech emergency rooms other than for what are considered **true** emergencies. **Make sure you know and read the definition of emergency care in the covered benefit section of your insurance handbook.** There may be a procedure you are required to follow before seeking emergency care, such as calling your primary care physician. Failure to do this may result in a "financial penalty" to the insured, i.e. no reimbursement for non-authorized emergency care. ***Some plans charge a higher copay for emergency services. Check your plan language to Identify co-payment responsibility.***

Who determines length of stay in the hospital? Only physicians have the legal and medical authority to decide when hospital inpatients are ready to go home. Managed care plans cannot discharge patients from the hospital.

The fact is, hospital length of stay is a complicated issue. There are few hard and fast rules about how long a patient should stay in the hospital, and in recent years managed care plans have been the center of controversies for allegedly encouraging the practice of sending patients home too soon. Studies and data on inpatient hospitalization provide information on the average length of hospitalization for all kinds of cancer patients, but this data provides only general guidance for how long a specific patient may need to stay in the hospital. Additionally, medical technology is helping move patients out of the hospital more quickly than ever. The decision needs to be made based on each patient's specific situation, including a judgment by the physician of whether it is safe and medically appropriate for a specific patient to receive inpatient or outpatient care.

Prior to hospital admission, patients should communicate with their physician about their anticipated length of stay based on the physician's experience. During hospitalization, physicians should communicate with their patients about when they may be discharged, what criteria are used to make discharge decisions, and what after-hospital care plan will be necessary.

Remember, a managed care plan cannot discharge patients from the hospital. Only a physician has the legal and ethical responsibility to do so. Patients or physicians who are pressured by a managed care plan for a discharge that appears too quick should contact the plan's medical director to discuss the situation in detail. The patient may also file a complaint with the plan. Patients also may wish to notify their state insurance department or attorney general's office regarding this issue.

B. COST VS. BENEFITS

Managed care plans vary widely in the cost of services offered. It may be tempting to base your selection primarily on the periodic, out-of-pocket costs to you. You can't be sure that the least expensive plan will give you all the medical services you need. The two primary costs incurred are the ***premium*** (your portion of the cost of the policy), and ***out-of-pocket expenses*** (those expenditures you must make in addition to what the insurance pays for health care services). Out-of-pocket expenses include:

- **Co-payments:** the fixed dollar amount paid by a member at the time of service (i.e. office visits or prescription drugs).

- **Deductibles:** the flat dollar amount that must be paid before receiving the plan benefits.

- **Coinsurance:** the portion you must pay for services, usually expressed as a percentage of billed charges. The deductible and coinsurance typically apply to the annual OOP (out of pocket) maximum. Copays are usually in addition to deductibles and coinsurance and many times do not apply to the OOP maximums. Some plans have "Dual OOP", meaning there are different amounts due by the member when choosing an in-network provider as opposed to an out of network provider. **Out of network deductibles, copays, and coinsurance** are typically **higher for the member; In-network** costs of those same responsibilities are typically **lower for the member.**

What other out-of pocket expenses will be incurred? Two potentially high out-of-pocket expenses you should ask about include: **1) the cost of non-formulary prescription drugs and 2) the cost of using out-of-network providers.** These are health care expenses that are **not** part of the managed care network contract.

What managed care plan gives me the best and most complete coverage for the most affordable price? In the Summary Plan Description, review the section that is sometimes called ***"Your Share of Expenses."*** Look at the definitions of **deductibles, co-payments** and **coinsurance**. Does the co-payment seem affordable for the services you need and use most often? Be sure to look at the section of the policy listing payment schedules - noting the **annual out-of-pocket expense** limit for both in network and out of network (OON) providers. Understand the annual out-of-pocket expense limit for OON does NOT include charges above Usual and Customary; these charges incurred are in addition to the limits listed. Then check the lifetime maximum. Optimally, choose a plan in which this is unlimited or has a high lifetime maximum, in excess of one million dollars ideally.

C. SERVICES OF THE PRIMARY CARE PHYSICIAN

Choosing your primary care physician (PCP) may be the most important decision you make when first enrolling in a managed care plan. To assist you in the process, obtain the Provider Membership Directory which may be identified as a listing of member providers or a list of participating doctors. This information is available from the customer service department of the insurance company or your employer's benefit manager. Ideally, you want to choose a plan in which your personal physician is a member or in which you can enroll your physician's name with the insurance company. As you seek more specific information, ask the following questions:

- Can you choose more than one PCP for your family?
- Is there a large choice of primary care doctors and specialists?
- How long is the average wait to get an appointment with the chosen PCP?
- Can you see the same doctor consistently?
- When and how can you change doctors if you are dissatisfied?

If you have to choose a new doctor, talk to family and friends for suggestions of doctors they know and respect, and who are members of the participating network. Be certain to select a physician who treats illnesses you have or may be genetically predisposed to developing, such as asthma, diabetes, cancer or heart disease. Know the physician's qualifications such as board certification. This means the physician underwent additional training in his specialty and passed a certification exam by a board of peers. Ask the doctor if he supports patient participation in the treatment process. You may choose to interview a physician before making your decision. If so, ask about access to care. Questions include:

- Does the practice have **extended hours** such as evenings and weekends?
- How long does it take to get an appointment for sick visits and well checkups?
- What are after hours procedures?
- Does the physician practice at the hospital of your choice?

If an HMO has centralized services, ask if you will see the same physician each time you go to a clinic. Ask about usual wait time to see a specialist and what procedure you must follow. Remember that in many HMOs, the primary care physician must approve referral to a specialist and must also approve his subsequent recommendations. If you have a particular need for a sub-specialty i.e., oncology, cardiac, pulmonary physician, try to find a primary care doctor with an interest in that medical specialty.

When and how can you change doctors if you are dissatisfied? Most plans have a cut-off date each month by which you must give written notification if you want to change doctors. Depending on your plan, you may be allowed to use a new doctor the next month. Be sure to ask if the Provider Membership Directory is current regarding doctors taking new patients. The waiting time to see a doctor is often the most common complaint many members register about their plan. Caution: not all doctors listed in the Provider Membership Directory may be available to you. Talk with the managed care plan about your access to any physician on the list. Have them identify their limitations.

D. PRESCRIPTION DRUG BENEFITS

When evaluating a health plan it is also important to know what kind of prescription drug benefits the plan offers. Depending upon the plan, there are several systems that have been implemented in efforts to control costs. Some plans offer a "generic only" plan. In this type of system, the plan will only cover the cost of generic drugs. If you are taking a medication for which there is no generic alternative then you will be required to pay the full price as it will not be covered by your plan.

Another system in place is called a **Tiered System**. Again, in efforts to control the costs of medication, many managed care plans have implemented this type of program. The **Tiered System** provides levels of reimbursement depending upon which tier your medication may be classified. For example, a Tier 1 drug, would provide the highest reimbursement available leaving the consumer with only a $10.00 co-pay. A Tier 2 drug may have a $20 co-pay, and a Tier 3 drug could have a $30 or $40 co-pay depending upon the plan. When filling a prescription it is important to review the tiers and determine under which tier your medication may fall. If you are having a difficult time meeting your co-payment each month, then you may want to have your physician review the tiers your plan has in place to see if there is an alternative medication that would be eligible on a lower tier. Also beware of tiered plans that require a **co-pay percentage** on high level drugs as the average price of these products may be hundred or even thousands of dollars, leaving the beneficiary with an unaffordable out of pocket responsibility.

Finally, another system that many health plans have implemented is called a "Preferred Drug List" or PDL. A PDL is a list of approved pharmaceutical agents for a specified diagnosis. If your medication is not on this list, you may have to provide documentation of medical necessity and file an appeal to the health plan to get your medication covered.

E. PROVIDER NETWORK AND GEOGRAPHIC SERVICE AREA

Be sure you inquire from the Provider Membership Directory which providers are included in the network and where they are located in your community. If you live in one community and work in another, ask if routine care can be received in either location.

A potentially serious problem may arise if you need to go outside of the plan's service area for specialized treatment. While you or your physician may choose one location, the network may have an arrangement with another facility not in the immediate proximity of your home. Try to avoid this problem by inquiring before the need arises.

If the plan redirects you out of your service area for specialized care, ask if they pay ancillary expenses (such as travel costs or lodging). Be sure to ask how long they would pay these and if there are any limits to this support.

Does the managed care plan include a strong network of providers in an acceptable service area? Are the hospitals, clinics, labs, pharmacies and physicians convenient for your use? **Ask if you must go to different places for different services.** Some physicians perform only routine procedures in the office setting. You may be required to go elsewhere for additional care (i.e. laboratory testing). Some large multi-specialty practices have many services available in one location. **If you have a child away at school, ask if the network of services extends to that area or if you are able to apply for an exception for the dependent child.**

F. COMMITMENT TO QUALITY OF CARE AND SERVICE

What measures of quality care and satisfaction of service are available? It is worthwhile to find out if the plan has been accredited by the National Committee for Quality Assurance (NCQA). The NCQA, the most common accrediting body for network plans, is an independent, non-profit review organization made up of groups of like providers of service and has consumer representation on its board of directors. Please refer to Part I: Understanding Managed Care Terminology: A Reference Manual of our Managed Care Answer Guide for a definition and brief discussion of the NCQA. While not an absolute standard, **accreditation is an effort toward validating quality of care provided by managed care plans.** Key areas reviewed by the NCQA are utilization review, quality management systems, provider credentialing, clinical record review and member rights and responsibilities. Once an organization has been reviewed, it is given an "accreditation status"- either full, one-year or provisional accreditation which is contingent upon specifically defined criteria. If the plan does not comply with a number of NCQA standards, or has a problem that poses a great risk to quality patient care, it may be denied accreditation. This accreditation process seeks to assure consumers that they will receive quality care by their managed care plan. Their website may be reached at **http://www.ncqa.org/.**

While the accreditation process is one seal of approval, it does not measure outcomes of care. The process doesn't let us know how many people got better or worse as a result of a procedure being performed. More importantly, it doesn't measure patient satisfaction.

Other measures of quality service are the number of board-certified physicians that participate in the plan and the number of physicians who leave the plan each year. Ask how the plan verifies physician credentials and clinical competence. Physicians may leave a managed care plan voluntarily, because of a low reimbursement rate, or they may find the plan's guidelines too restrictive. You may or may not find out if the physician was asked to leave because he did not meet the plan's standards. It is worth asking.

G. CUSTOMER SATISFACTION

How do enrolled members feel about the plan? There are various objective forms of measurement used to determine "quality services" given by managed care plans such as accreditation, HMO report cards and/or publications produced by the industry, you would be wise to look at any that measure customer satisfaction. Look for surveys that compare plans operating in the same geographic service area. Ask if you can see the results of any member satisfaction surveys. Talk to people within your company insured by the same plan. Check with your provider about their annual member's survey that measures quality of care and customer satisfaction. Finally, you may want to ask about the number of people who have voluntarily left the plan and the reasons why. People will tend to be happy and satisfied with a plan if they believe they get the care they need when they need it and are satisfied with their doctor. Consumer surveys are often available upon request from your benefits manager or directly from the HMO Service Representative. The National Committee for Quality Assurance (NCQA) mission is to provide information that enables purchasers and consumers of managed health care to compare plans based on quality. Their web site may be reached at **http://www.ncqa.org/**. Another vehicle that may be useful is to search for "managed care" through Yahoo or Google.

You may gain important insight about a managed care plan by simply talking with plan representatives. **Check out your responses to these questions:** Are staff courteous and friendly? How is navigating through the phone system? Are the customer service department representatives knowledgeable and organized? Do they return phone calls promptly with the information you requested? If you like the answers to these questions, that's a favorable sign of a customer-oriented company.

H. LIMITATIONS, MAXIMUMS, OR EXCLUSIONS

Lifetime Cap refers to the maximum dollar amount of benefits available to a consumer in a managed care plan during his or her lifetime. This amount becomes important when confronted with a life-threatening disease or accident that requires prolonged care involving expensive therapeutic intervention and support such as an extended hospital stay in acute care units, repeated chemotherapy protocols, home care support through medical personnel and/or equipment. Once the lifetime cap is paid out, the insured has no additional coverage through the plan. **All expenses incurred after the lifetime cap has been reached, will be out-of-pocket costs that the patient is responsible to pay.**

I. COBRA

Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federally mandated conversion of existing health care coverage through your employer to a private plan of coverage. This conversion occurs when you experience a qualifying event such as job termination or disability that results in an inability to perform your job. COBRA coverage provides the same healthcare coverage as that provided by the employer prior to the qualifying event. The COBRA rate may be up to 102% of the amount previously paid by the employer or the employee for insurance coverage. Premiums may dramatically increase because the employer may have been subsidizing the cost of employee's health care. The employer must formally notify the qualified beneficiaries in writing within 14 days of the precipitating event that COBRA coverage is available and the amount due from the employee on a monthly basis to maintain this coverage. This notice will also identify the due date for each month's premium and the correct mailing address to which the premium must be sent. **Failure to pay the premium on time will cancel the coverage.** Under ordinary circumstances COBRA coverage is only available for a period of 18 months. However, there are special provisions for disabled beneficiaries which may allow for an 11 month COBRA extension. To learn more about your rights to health benefits under COBRA you may visit http://www.dol.gov/ebsa.

Upon termination of the 18 month period of COBRA coverage, the plan member may be able to convert the policy to a private policy. This conversion may result in increased premium rates as well as decreased benefits to the member. These benefits include, but are not limited to, medical care coverage and drug co-pays.

SUMMARY AND CONCLUSIONS

If you are considering joining a managed care plan, it is in your best interest to carefully and critically review and evaluate the choice of plan options available to you. Our questions and criteria guidelines outlined in this publication may be useful as you seek information about your options in selecting the best plan for you and your family.

With more than 66 million people already enrolled in HMOs nationally and the number slated to grow, quality and accountability are issues that are becoming increasingly scrutinized by corporations. Employers save money by offering managed care health plans and as a result, HMOs are now the insurance offering of choice since an HMO may be the most economical plan.

Managed care plans may have lower costs and less financial risk compared to traditional insurance however, members must take greater responsibility for managing their own care. You may not have the unrestricted choices of a traditional fee-for-service indemnity plan. The physician may need to receive pre-authorization from the managed care plan to deliver services and/or treatments appropriate for the management of your medical condition. Pre-authorization is prior approval by a managed care plan for a member's medical treatment, test or surgical procedure that is to be performed on an outpatient basis. The plan you select becomes your healthcare partner. Be sure they are committed to accessible, timely, quality, affordable care.

Dealing with a managed care plan may add an additional layer of administrative responsibilities to medical care which must be carefully negotiated. As a member of a managed care plan, you must be an assertive member of the healthcare team and always act as your own advocate.

The purpose of this Managed Care Answer Guide is to enable you to become an informed, educated consumer of your managed care product. Information will empower you, so don't be afraid to ask questions!

PART III: UNDERSTANDING THE PROVISIONS OF YOUR PLAN

The purpose of this part, *Understanding the Provisions of Your Plan*, is to assist members of health insurance plans, particularly HMOs and PPOs, to have a greater understanding of what the plan covers. This part profiles common questions to ask the insurance company in order to specifically define your coverage or benefits. The type of plan you have can affect who directs your medical plan of care (the physician), where that care can be delivered (the facility providing services), the length of time certain services can be administered (precertification/predetermination), and any additional cost of treatment to you (co-insurance).

Managed care, by definition, is a comprehensive method of managing and coordinating the medical care you receive. The goal of case management is to coordinate and facilitate access to medical care, while adhering to the guidelines and provisions of your health plan benefit. A wise course of action is to be proactive by finding out what your policy covers and how to access medical care services.

QUESTIONS ABOUT YOUR COVERAGE

Whether you are newly diagnosed with a chronic, debilitating condition or facing choices of new or additional treatment recommendations, review your policy for clarification of benefits available regarding providers. Review all of your covered benefits. Obtain the most current copy of the Provider Membership Directory and read it thoroughly to be sure the providers you want to use are included in it.

The following questions and points of discussion are areas for your review and may serve as a guide to help you solve potential problems.

What do the words "usual, customary, and reasonable" mean? Is there a limit to the coverage for my particular disease or its treatment?

Usual, customary, and reasonable, often abbreviated on insurance forms as UCR, is a method of determining payment the insurance company will allow for a claim. UCR is determined by the insurer by comparing charges of **providers of care** to those of "like" providers of service in the same region or community.

If you choose to see or be treated by a physician who is considered outside of your net work of providers, you may be subject to the UCR. What does this mean? This means that the out of network physician (who is not contracted by your insurance company) is not liable to provide you with a discount after the insurance has paid according to the contract. Therefore, you may be responsible for the difference in the charges and be balanced billed from the OON provider with no discount provided.

The extent of benefits the insurance company will cover for your particular type of disease is defined under "Limitations." They are important to understand.

- **Limitations are restrictions placed on a benefit.** Usually this refers to the number of times for use or the circumstances of use for a particular service or treatment. This can be in the form of a visit limit, specific dollar limit, or a specified number of days allowed per calendar year. In addition benefits may be limited to lifetime or "per illness or injury" (typical with Hospice and Skilled Nursing Facility Benefits).

- **Exclusions are those services not covered at all.** Excluded services cannot be accepted as within the scope of "medical practice." Conditions not considered related to health or illness, or those specific services excluded from the plan by request of the plan contract parties (generally the insurance group health agent and the group or employer). "Experimental Procedures" as defined by the insurance company may be found in the list of exclusions.

How is "experimental" care defined and funded? When selecting a plan, look closely at the marketing materials supplied by your plan and your employer to see how the plan defines experimental care, and under what conditions the plan might cover such care. This is very important for cancer patients and those with chronic, debilitating diseases who are joining a new insurance plan, or consumers who believe they are at high risk for the disease (for example, because of a strong family history of cancer, diabetes, or high blood pressure). If the plan's materials do not clearly define the term, and how the plan uses it, consumers can ask their employers to let them see the actual plan language. Consumers also can call the plan and ask plan administrators to provide them with information on the plan's coverage of experimental care such as use of off-label drugs and care in clinical trials, which are discussed in greater detail below, and guidelines on how the plan decides what cares is experimental.

Some consumers in managed care plans have reported problems getting access to care because their plan considers a particular product or service experimental. When plans deny coverage for a service on this basis, the plan will not pay for the care. Most managed care plans routinely exclude experimental care from coverage in their contracts.

While there is no widely accepted and utilized definition of experimental care, plans typically regard it to mean that the medical benefit of a particular service has not been proven to the plan's satisfaction. Thus, each plan defines the term as it wishes and may apply it differently from contract to contract. Some of the things that plans commonly exclude from coverage as experimental are the following:

- **Off-label use of some drugs.** In some cancers and chronic diseases, physicians and patients want to use a drug for a diagnosis other than what the drug is approved for by the U.S. Food and Drug Administration (FDA). Plans make case-by-case decisions on whether to cover off-label use of the drug and may deem some off-label uses experimental, if the plan believes there is insufficient scientific basis to justify it. Some state laws require plans to cover off-label uses of a drug when there is adequate evidence for the value of the drug published in the medical literature and leading drug reference books.1

- **New tests or treatments.** As medical technology produces new services for patient, managed care plans evlaluate these new services to make policy decisions about what they will cover and pay for. They review published medical studies of the new test or procedure and government approvals (where applicable), and consult with leading specialists. After this review, if the plan's administration believes that a new test or procedure has not been sufficiently evaluated, or its effectiveness is uncertain, the plan may designate the service as experimental and refuse to provide coverage and payment.

- **Clinical trials.** Plans may refuse to cover the costs of having their patients treated in clinical trials. Because clinical trials are research studies, some plans may conclude that care in a clinical trial is, by definition, experimental, and therefore, excluded from coverage. For many cancer patients, clinical trials offer state-of-the-art treatment. Because clinical trials are such an important part of caring for cancer

1 These reference books include the following: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information.

many states have passed laws related to insurance coverage for clinical research studies. that require health insurance companies to provide coverage for clinical trials, lack of insurance coverage can keep patients who might want to be in a clinical trial from taking part in it. To find more information about the laws in your state, please visit:**http://www.cancer.org/docroot/ETO/content/ETO_6_2x_State_Laws_Regarding_Clinical_Trials.asp**

The issue of whether something is or is not experimental is not black and white. There is often disagreement among plans, patients, and physicians about whether a service, such as a bone marrow transplant, is an experimental treatment for a particular diagnosis. There have also been many state and federal court cases in which patients and physicians have challenged plans' decisions not to cover and pay for care the plan labeled as experimental, but which the patient and physician believed appropriate. The courts have ruled that whether a service is or is not experimental may depend not only on published medical studies, but also on whether the physicians in a community believe it is appropriate for a particular diagnosis, as well as expert opinion. Thus, standards of care vary around the country. If a managed care plan refuses to cover and pay for a treatment or test on the grounds that the service is experimental, consumers and their physicians need to work closely together to challenge the decision.

When consumers and their managed care plan disagree over whether a test or treatment is experimental, consumers can appeal the plan's decision. This process starts with notifying the managed care plan. All managed care plans have an appeal process for reviewing denials of care. Consumers should file an appeal by writing a letter to the plan, and get a letter supporting their position from their physician. The physician also should submit to the plan copies of medical studies and expert opinion that support the appeal.

If a consumer and a plan cannot resolve their differences, the consumer may want to consider filing a complaint with a state regulatory agency, such as the state department of insurance or the attorney general's office. A complaint to these agencies should include copies of all correspondence with the plan and copies of relevant medical studies. The state agency may be able to help mediate a resolution to the complaint, or it may intervene directly on the consumer's behalf if it discovers that the plan is not adhering to the terms of its contract with you or is violating a provision of state law. State laws vary in how much authority these agencies have over managed care plans.

In some cases, consumers need legal help, and might consider filing a lawsuit against the plan to get the care they need. Consumers in a self-insured plan (employers or plans can identify which ones are self-insured) cannot turn to state regulatory agencies for help. They need to speak with a lawyer who has experience helping consumers pursue complaints against self-insured plans.
Self-insured plans are regulated by the federal Department of Labor. You may contact them at **www.dol.gov.**

An ethics committee is now part of the formal review system in many managed care organizations. These committees may have medical and legal representatives, ethicists, and other health care providers as members. One of the functions of an ethics committee is to review cases in order to develop coverage policies and criteria for benefit application. For a more detailed explanation and review of this subject, see The Ethics of Efficiency: A Guide to Medical Decision Making for Managed Care Plans in an Antagonistic Era, by Dr. William Osheroff in the list of references.

What questions need to be answered to define breast cancer coverage? If you have breast cancer, the following questions may be of particular interest to you. Are the following covered as part of my benefits:

- treatment for recurrence of the primary cancer.
- high dose chemotherapy.
- stem cell transplant (autologous and allogeneic), Autologous Bone Marrow Transplant.
- wigs and hair pieces, breast prosthesis
- surgical repair of both breasts even if single mastectomy covered.
- counseling/supportive services.
- coverage for new/innovative therapies and biologics.

Is the specialist physician you want available? Is the specialist physician you want available? Some policies limit your access to medical care to physicians listed in the Provider Membership Directory. This publication should be available from the customer service department of the insurance company. Obtain the most current copy available. Be sure the specialists listed in the directory are ones with expertise in the treatment of your particular problem and that they are available to you at the time you need them. Confirm with your employer's benefit manager and with the Customer Service Department of the insurance company whether this specialist is included with your plan. Call the physician's office directly to verify what you have been told by the plan representative and make your appointment. Once you are receiving treatment from the specialist, be sure to periodically check that he remains a participating provider in the network. Do not assume the Provider Membership Directory remains current or accurate for any length of time.

What is the procedure if you need to have tests, to see a specialist or to be hospitalized? Most HMO plans require you to obtain a referral from your primary care physician (PCP) to see a specialist or receive special tests and procedures. Plans may vary in the process. Some require the doctor to call into a central office before giving a referral, while others allow physicians greater flexibility in decision making. HMOs, PPOs, and most fee-for-service plans require doctors to get approval before admitting patients to the hospital; this is known as precertification. Precertification has a predetermined set of guidelines for hospital admission and length of stay in the hospital. You may want to ask the plan representative what those guidelines are and how many days are approved for a planned hospitalization. Emergency hospitalizations generally have additional or different guidelines. Check your plan.

If you are approved to have a certain type of procedure or treatment, ask where it can be performed. HMOs may use only certain hospitals or a designated medical center as the only place you may go to have a specific treatment. A "carve-out" is a payment strategy in which the payer (the insurance plan) separates a portion of the benefit by contracting with one exclusive provider to cover a specified service. Many HMOs and insurance plans use this strategy to improve their control of these payments to providers of these services.

What if the primary care physician or the plan will not give approval for a referral to a specialist you request? If your primary care physician or the plan administrator refuses to allow the referral or services you believe you need, find out how you may appeal the decision. The appeal or grievance process is defined in your health plan.

What questions do you need to ask your employer if you become totally disabled? If you become disabled and cannot return to work, check for answers to the following questions from your employer benefits manager:

- How long will the policy stay in effect during a medical leave of absence?
- How much of the premium must you pay?
- Are benefits "changed" or reduced while on disability?
- If you become eligible for Medical Disability (documented disabled for two years), will the managed care plan agree to become your secondary insurance?
- What are the short term benefits available through the company disability coverage?
- What are the long term benefits available through the company disability coverage?
- Are there specific services or benefits excluded from coverage through the disability plan?

What is the role of Utilization Review? Utilization review, or UR, is a process by which an insurer reviews the care a patient receives to assess whether it was appropriate and provided in a cost-effective manner. UR is most often associated with indemnity insurance plans, but also is used in other forms of managed care, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). In all these cases, UR is a means of controlling the use of services by patients, and thus, the costs of care. Managed care plans use UR in a number of ways:

- Assess hospital lengths of stay, and keep patients in the hospital no longer than is necessary,
- Limit the number of visits a patient makes to a particular health care provider, for example a specialist,
- Choose the setting in which a patient receives care, such as inpatient versus out patient care, and
- Manage catastrophic illness, to help coordinate the care provided and to move the patient along from one phase of care to the next.

UR programs are eligible to be accredited by the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (AAHC/URAC). The AAHC/URAC is a private non-profit agency that assesses how UR programs measure up against national standards for confidentiality, staff qualifications and credentials, program qualifications, quality improvement programs, accessibility and on-site review programs, information requirements, UR procedures, and appeals. UR programs that meet standards in these categories are accredited, or approved by the AACH/URAC. Accreditation is not mandatory, however, and not all UR programs seek it.

Ideally, UR should help a consumer get the best care at the best price in the right setting. Consumers in managed care plans can appeal decisions by the plans' UR departments that they believe are inappropriate. They should work with their physician to document for the UR department their disagreement with the decision and outline why another treatment option is preferable. If necessary, consumers also should file a complaint with the state agencies, such as the health or insurance departments, or the attorney general's office, or the federal Department of Labor (DOL).

GRIEVANCE AND APPEALS PROCESS

The Grievance Process begins when a member lodges a complaint with the customer service department of the managed care organization. If it cannot be resolved at that level, the member may file a formal, written grievance, or complete a special grievance form. The nature of the problem, what has been done to solve it, and the member's opinion of how the problem should be resolved need to be included in the written complaint. Retain a copy of your letter.

Most insurance plans use a Grievance Committee structure as the next level of review of a member's complaint. The committee members, composed of representatives of various departments of the company, meet periodically to review written grievances. The committee may find in favor of the member or uphold the original actions of the plan. If the member is not satisfied with the committee's decision, he or she can request in writing a rehearing. Another committee will review the facts of the case and issue their decision, either in favor of the member or upholding the first committee's decision. Some plans have higher levels of appeal. There may be further recourse available. Check with your policy.

The Appeals Process involves problems with payment for medical services/benefit decisions. When the managed health care plan denies a request for specific medical service or refuses to pay for same, the member may appeal the decision through the written appeals process. The member will need to address why the service should be covered and submit any medical records or documentation to support the position. A written statement from the physician recommending the denied services can offer a professional medical opinion to further support of your appeal.*

The differences between a Grievance and an Appeal include the following:

- A Grievance concerns misconduct that may or may not deal with denial of benefits. A Grievance may deal with issues such as physician incompetence, quality of care concerns, and/or redirection to another treatment facility for care that is not the site recommended by the treating physician.

- An Appeal deals only with respect to denial of benefits.

Many states also have specific mandates regulating the complaint process managed health care organizations must follow. Depending on the state, the regulations may be under one of the following departments: the Department of Insurance, the State Attorney General's Office, or the Department of Consumer Affairs.

Denial of pre-authorization does not necessarily mean benefits will be denied; however, it does mean that the patient must be persistent and engage their physicians' support in providing strong medical justification to reverse an initial pre-authorization denial. Having the treating physician update protocols and patient consent forms will be beneficial in this process.

Appeals follow many formats defined by your managed care company:

- Written appeal in which all information is submitted in writing to an appeals representative within the managed care organization for reevaluation. This is typically the first appeal format utilized.

*Note: if there exists a life-threatening situation and the plan won't pay for a treatment or test you need, do not hesitate to go outside the system to receive care, even if you have to incur costs to do so.

- Hearing appeal in which all parties to the appeal are present before a singular or group appeal panel. This is typically utilized in a second hearing of an appeal.

- Third Party appeal in which all appeals information is provided to a third party review organization for evaluation of medical efficacy of the therapy prescribed. This organization is charged with rendering a written decision in which they support their position in writing. This is an appeal method utilized by insurers as a standard appeal practice. The type of appeal process is determined by the managed care company.

Remember, you may incur costs if you seek medical care without preapproval. Check your contract to see what remedies you have if the insurance plan does not approve your request.

The details of specific insurance plans' grievance and appeals processes vary widely from plan to plan and state to state. All systems are designed to make the insurance plan responsive to customer needs while allowing some means by which members may challenge the system.

A word of caution: while the Appeals and Grievance Process allows you the right to be heard, it does not ensure you the right to treatment.

NAVIGATING THE APPEALS PROCESS

THE SIX PRIMARY STEPS TO NAVIGATING THE APPEALS PROCESS

1. Know the rules and procedures to follow.

- As a first step, enrollees are usually encouraged to call the plan's Customer Service Representative or benefits manager with questions or to voice concerns.

- Obtain a copy of the plan's description of Coverage and Grievance process from your plan's benefits manager. This is known by different names in different plans ranging from "Your Health Benefit" to "Your Health Care Coverage." Steps to be followed in the appeals/grievance process are usually explained in writing as part of your policy.

- Instructions for submitting a complaint in writing should be in your plan's description of coverage and grievance process. If you find any of these instructions omitted from your policy or you cannot get the complete information from your insurer, contact the state insurance commissioner's office to get clarification on the procedure to follow to procure the proper instructions.

- A simple letter to your insurer about denied services, as well as a statement of your intent to appeal, is generally sufficient to set this process in motion. The letter should be sent to the person or persons issuing the denial. Retain a copy of your letter and follow up in a few days with a phone call to ensure receipt of your letter.

2. Summarize the problem or situation in writing.

- Describe the problem and what you think the solution should be in writing.

- Ask your treating physician to write a letter of appeal to the insurer to accompany your letter.

- Send your appeal package certified return receipt. This way there is never a question of whether or not your appeal was received.

3. Always document the sequence of events as they occur.

- Keep written, dated, chronological notes on file from the beginning of the appeal. This helps you stay organized and is a useful reference.

- Be sure to document all contacts with the managed care plan representatives. Get the name, title, and phone number of each person with whom you talk.

4. Communicate clearly, concisely and calmly.

- Be persistent, and remember that your goal is to get them to accept your solution.

5. Always insist on specific details: How, when, who, where, and how much.

- If a resolution is promised to you, ask for details in writing, such as a specific date by which your grievance will be resolved. If you do not understand, ask for clarification.

- Ask whom you should contact if you do not receive acknowledgment of your appeal in writing.

- Ask when and where you will have your grievance heard and ask how long it will take for a final decision. Ask who may attend the meeting, including your physician.

- Remember the cardinal rule: Always write down the name, title, date and phone number of all parties you speak with at the insurance company.

6. Be persistent if your grievance is not resolved to your satisfaction.

- Ultimately, you may choose to seek third party counsel which may be through a board of arbitration or through an attorney.