Navigating Managed Care

A consumer's guide to managed care

Deborah Senn
Washington State Insurance Commissioner

Dear Health Insurance Consumer:

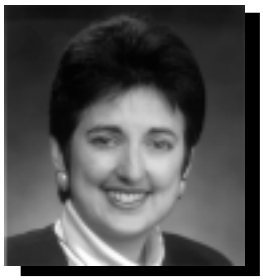
In the past few years, a lot has changed in health care.
To help you keep up with these changes, my staff has prepared this consumer guide. I hope it will help you understand

- how managed care works
- what kind of health plan is best for you
- how to get the best care from your health care providers.

I cannot emphasize enough how important it is for you to have adequate health insurance. Uninsured people sometimes avoid getting treated for medical conditions that may escalate into major health and financial problems. No one can guarantee you good health, but you can tip the odds in your favor by

- obtaining health care insurance that meets your needs
- having a good network of health care providers
- becoming a wise consumer!

If you have questions and concerns, you may call our toll-free Consumer Hot Line at 1-800-562-6900.
Please let me know how else we can help.



Sincerely,

Deborah Senn
Washington State Insurance Commissioner

What's New In Health Care?

Old Fee-for-Service (Indemnity plans)

New Managed Care

Old Fee-for-Service

Fee-for-service plans allow consumers to act independently in choosing health care professionals and even hospitals. Doctors and other providers in individual or group practice are paid by the insurance company for each service (e.g., office visit, tests). Fee-for-service plans, which are disappearing, cost more than managed care plans. Usually there is a deductible (amount you pay out of your own pocket before your coverage kicks in).

Example: Flora X. has a sore throat and goes to an internist whom her friend sees. The doctor orders a throat culture and charges Flora for the office visit. The lab charges Flora for the culture. The doctor and lab forward Flora's bills to her insurance company. (She has been to several doctors this year and so she has already paid the deductible.) When Flora doesn't get better, she goes to a throat specialist recommended by her nephew. Flora chooses to have surgery in a teaching hospital. The specialist performs surgery and bills the insurer. So long as the services and procedures are deemed medically necessary, her insurance company pays the bills without questions.

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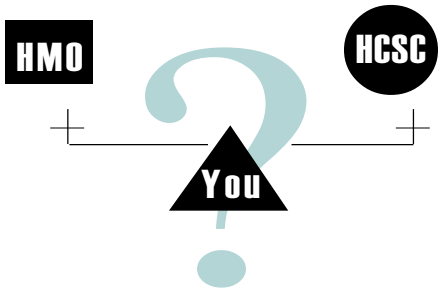
New Managed Care

Managed care plans require consumers to obtain their health care from a large organization or network of professionals. Tests or treatments may be limited to keep costs down, and physicians may be given financial incentives to limit services or increase the number of patients they treat. In addition, the organization may put a ceiling ("capitation") on reimbursements to the doctor. ***If you must choose your doctor from a certain list or only go to certain health care facilities, you are in a managed care system.***

Example: Walter Y. has insurance with a managed care system. At the outset, he must choose his "primary care provider" (similar to a family doctor) from the insurer's list. Months later, when he has a sore throat, he must go to this physician who acts as a kind of "gatekeeper," deciding if Walter needs diagnostic tests or even specialized treatment elsewhere. When his throat doesn't heal, Walter wants to go to the specialist his neighbor Flora saw. It turns out that this doctor is not on his carrier's list. Instead, his primary care provider agrees to let Walter see a different throat specialist, who is part of the network. The specialist recommends surgery but before Walter can have it, he is required to get a second opinion.

Do You Know Your Health Care Alphabet?



There are two kinds of Managed Care Systems:

Health Maintenance Organizations (HMOs)
Health Care Service Contractors (HCSCs)

Health Maintenance Organizations (HMOs) are insurance carriers that require you to use the services of doctors, other health care professionals, and hospitals in their **network.** Often these providers are directly employed by the HMO.

Usually you pay less out-of-pocket for services through an HMO. HMOs relieve you of most of the paperwork. And, you're covered for preventive care, such as annual check-ups. Most HMOs allow you to change your Primary Care Provider if you decide you would prefer to switch. *Remember when Walter had a sore throat? He had to go to his PCP before he could see a specialist.*

Health Care Service Contractors (HCSCs) are also insurance carriers. They contract with health care providers for prepaid health services for their subscribers. Like HMOs, HCSCs deal mostly with managed care plans.

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However, HCSCs usually have more flexibility and may offer greater choice for you between plans. For example, one HCSC plan may offer more options to see a doctor outside the network. Another HCSC plan might offer what is known as a **"Point of Service"** option to a subscriber traveling to another state or country, where network physicians are not available. Still a third might parallel an HMO setup.

What's the difference?

From a consumer's standpoint, there is little difference between HMO managed care and HCSC managed care. Both kinds of insurers use PCPs, both use networks of preferred providers, and both may use co-payments. You should shop for the plan that best suits your needs, regardless of whether it is offered by an HMO or an HCSC.

How do you benefit from health care reform?

The Washington State Legislature passed several new laws in 1993 that ensure access to health care for **all** state residents. As a result of these reforms, you have the following rights:

- √ You cannot be turned down for health insurance, regardless of your health, past or present.
- √ You cannot be charged a different rate based on your current health. (Premiums may vary due to age, family size, place of residence.)
- √ You may receive a discount based upon how long you have been enrolled in a plan or if you are a non-smoker.
- √ You cannot be refused coverage or have a higher premium because of a pre-existing health condition (even if you haven't had insurance before). A plan must treat everyone the same for any illness or condition.
- √ You are entitled to coverage for a pre-existing condition after the first three months of a new policy. However, if you previously had insurance within the past ninety days, you do not have to undergo any waiting period for treatment of a pre-existing condition.

Managed Care

Before You Buy Health Insurance, Ask Yourself:

Yes	No	
❍	❍	Does anyone in your family have special health needs? If yes, list. _____
❍	❍	Do family members need to regularly see specialists?
❍	❍	Does anyone have a condition that would be made more difficult if she or he were unable to see the same physician or other health care provider ("continuity of care")?
❍	❍	Does anyone require the services of a particular hospital, clinic or other care center?
❍	❍	Is pregnancy a possibility for any family member?
❍	❍	Is there an on-going need for prescription drugs? If so, are they common drugs?
❍	❍	Does anyone need home health care or rehabilitation services?
❍	❍	Do family members travel regularly and/or extensively?
❍	❍	Does your family have other health needs? If yes, list. _____

Now that you know what your family needs in the way of health care, take a few minutes to learn what kinds of insurance are available.

Is employment-based health coverage best for you?

People usually obtain health insurance through their employer or their spouse's employer. Small businesses prefer to purchase a single plan for their employees. Larger companies or government often give employees a selection of plans from which to choose. "Fee-for-Service" or indemnity plans may still be available from your employer, but the reality is that almost all health coverage today is based on managed care.

What if your employer's health plan does not meet your needs? Perhaps the plan doesn't cover your spouse or dependents. Or it's too expensive. Or you haven't worked long enough in the company to qualify. Or you have to wait for an "open-enrollment" period (usually the same month each year). In those cases, you may want to look into buying your own individual policy.

What if you're self-employed or a sole proprietor?

You may be eligible for a small group plan that offers better benefits at a lower cost than an individual plan. To be eligible for small group rates, you must:

- derive at least 75% of your taxable income from your business, and
- have filed the IRS Form 1040, Schedule C or F, during the preceding year.

If you meet these requirements, you cannot be turned down by a health carrier for small group coverage.

What's Available For Individuals?

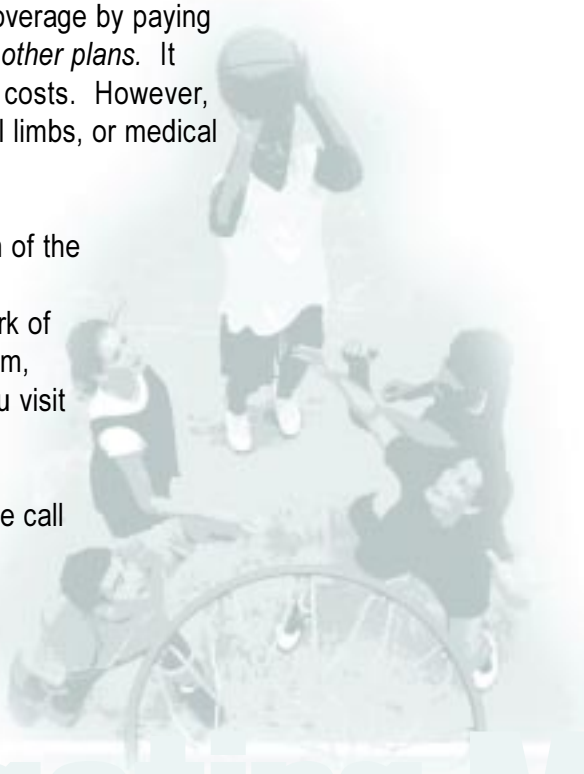
Basic Health Plan (BHP)
Basic Health Plan "look-alikes"
Commercial individual plans

Basic Health Plan (BHP)

The BHP is a managed care plan, sponsored and subsidized by the State. A limited number of slots are set aside for people who will pay on a sliding scale, with premiums based on income and family size. If the slots are full, you may get on a waiting list. However, anyone can obtain BHP coverage by paying the full premium. *The BHP is more affordable than many other plans.* It covers prescription drugs, maternity, and major medical costs. However, the BHP does not cover eye and hearing exams, artificial limbs, or medical equipment such as wheelchairs or back braces.

Local health carriers offer the BHP, under the supervision of the Washington State Health Care Authority. As is typical of managed care, you must use the services within a network of providers in your area. Besides paying a monthly premium, you will have to make a small "co-payment" each time you visit your health care provider.

For more information on the BHP or an application, please call 1-800-826-2444.



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Basic Health Plan "Look-alikes"

BHP look-alikes are offered by all carriers marketing individual health plans. The benefits are richer than the BHP, and rates are not based on a sliding scale, and there are no subsidies.

Commercial Individual Plans

Most individual plans, along with the BHP look-alikes, are based on managed care. Even so, they vary greatly from carrier to carrier and from plan to plan, with respect to:

- breadth of coverage
- premiums
- other costs (e.g., paying a portion of some services)
- cost-effectiveness for certain illnesses or services
- availability of services in your geographical area (e.g., specialists or maternity benefits)

Choosing the best plan for you

Comprehensive or Limited Coverage?

Every carrier must provide a brochure that compares the benefits of different plans, whether "comprehensive" or "limited." Evaluate the plans in terms of your family's specific needs.

A comprehensive plan covers most services, often after you pay a small deductible. It is more costly than a limited plan.

Example: Mary Q. has three small children who are prone to infections and allergies, and a husband with diabetes, a chronic condition. As a result of a blood clot, she herself is on a blood-thinner, which requires frequent testing. For her family, the high premium of a comprehensive plan is less costly than paying for extensive care out-of-pocket.

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A limited plan may offer you coverage for catastrophic losses while requiring that you pay for less serious illnesses or conditions.

Example: Roy M. has always been healthy, except for the year when a freak accident damaged his eye. The medical bills nearly bankrupted him. His parents have never been seriously ill and are long-lived. His limited medical plan requires a huge deductible, but he believes it is offset by smaller premiums, and will protect him in the event of a major health emergency.

Here are some examples of how consumers decide which plan fits their needs.

Maureen travels cross-country two weeks out of four, as a fund-raising consultant to various companies.

She needs a plan with a wide or extended provider network.

Rick and Sue-Ann have four boys who play soccer and football. She is overweight and Rick has frequent back problems.

Their family is choosing a plan with a low, out-of-pocket maximum.

Pippin is barely making ends meet with her two part-time jobs and her baby.

She is applying for the Basic Health Plan.

George's family has a history of colon cancer. Except for signs of Carpal Tunnel syndrome (he freelances, developing Web sites), he has not had any serious medical problems.

He is choosing a high-deductible plan.

Tish'a and Tyrone recently married and don't plan on starting a family until he gets promoted at work to manager.

Looking ahead, they choose a health plan with maternity benefits.

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Asking Questions . . . Getting Answers

It is not easy to evaluate health care plans. However, few decisions are as important as choosing health insurance. Check with friends (take into account their situation and how it is the same or different from yours). Read the insurers' brochures. If you don't understand certain provisions, call the insurer. If you are still uncertain, call our Consumer Hot Line at 1-800-562-6900.

Play What If. What if you had Plan X and next year was like this year?

By the end of December, how much money would it cost you for the premiums plus out-of-pocket costs (deductible + co-payment + uncovered services and/or prescriptions)?

Make a list of questions that apply specifically to your situation and get answers. For example, you might ask:

Is my favorite doctor or other health care professional part of the carrier's network?

Will I be able to choose my Primary Care Provider (PCP)?

Then, if I don't like her or him, what recourse will I have?

How will I get access to specialists?

How much more am I willing to pay to have more choices?

Are the services I need "medically necessary" and will my doctor back me up on that?

What do the carriers consider to be urgent and emergency care?

What options will I have if I disagree with the treatment plan?

What treatments are considered "experimental" and therefore not covered?

How is the carrier rated?

You may check with the National Committee for Quality Assurance regarding accreditation, ratings and complaints: Call toll-free 1-800-839-6487 or see the web site at http://www.ncqa.org

Which plan is right for you?

To help you choose the best plan for you, we have enclosed a chart that compares individual health care plans available in our state. Coverage varies by age, size of family, medical needs, and affordability. By reviewing your options, you will be in a better position to work with your insurer or carrier to obtain the medical coverage you want.

Please remember that the information is current at the time of printing this consumer guide. Updated information may be obtained from our web site at http://www.wa.gov/ins or by calling our office at 1-800-562-6900.

Are you in control of your health care?

You can be! Modern health care, especially managed care systems, can be frustrating. You may feel you can no longer choose a provider or decide whether to get an annual check-up. Don't let the system roll over you! The key to getting control is to become informed, assertive and active in managing your care. A good health care plan should make it easier for you.

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Additional tools to help you get control

If you've read this booklet, you should be familiar with how managed care works and how to purchase coverage. To make sure you're getting what your health carrier promised, please use the supplemental material we've provided in the back pocket:

A chart comparing what various carriers say they offer to subscribers. Use this to evaluate if what you are experiencing from your carrier is what your carrier says it is providing. If there is a discrepancy, please call us for help. If this material is not enclosed or out-of-date, please call us, or visit our web site for a current, on-line version. Demand straight talk from your carrier. Don't be shy about asking for explanations.

A postcard with questions you should ask your carrier—about your coverage and other consumer issues. Jot down their answers and mail the pre-addressed card to us. Be sure to include your name, address and phone number so that we can follow up.

Getting off to a good start with your health care provider

Decide what kind of relationship you want. Are you the type of person who wants to actively manage your own care, or would you rather "leave it to the experts"? Either way, you want to be sure that you are getting the best care. Know what's available. If you don't know, ask!

Managed Care

Choose your Primary Care Provider (PCP) carefully. Most managed care plans require you to designate a PCP from the providers in their network. Ask your carrier for a list of PCPs who are accepting new patients, and tell your carrier you want information about the providers, including

- education and certification
- professional experience
- any disciplinary actions that may have been taken against them by a professional association or government licensing agency
- a history of complaints or grievances with the carrier
- philosophy of medicine and care (If available, this may be one of the best tools you have in making your choice.)

If your plan allows for complementary and alternative providers to serve as PCPs, consider if their approach to care is right for you.
Ask your friends, acquaintances or co-workers for recommendations or experiences with particular providers. These may be more telling than the provider's medical training or professional background.

Plan your health care. Some plans and providers offer booklets, books, classes or on-line information to help you stay healthy or manage an illness. Be sure to ask what assistance is available.

Schedule a routine check-up once you've chosen your PCP.

- Before your appointment, take the time to write out information the PCP should know about your history or current problems, as well as any questions you have.
- If you feel you cannot be frank with your provider, you may have chosen the wrong person and might consider another choice. You should be able to communicate what you expect, and any information relevant to your condition or problems.
- Ask your provider for recommendations. "What would you do if you had this problem?" is one way to get a good answer. Tell the provider you want a frank opinion based on medical need, not what the carrier prefers.
- Ask for approval of routine care from specialists (e.g., if you need routine monitoring for cardiac functions).

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Getting The Best Care From Your Managed Health Care System

Don't let the "consulting nurse" prevent you from getting an appointment you need. Consulting nurses are usually skilled and knowledgeable in assessing your condition over the phone, but they are not your PCP.

Before your appointment, write down information about your problem or illness and your questions, so you won't forget to tell your PCP what's important.

During the appointment, be sure you understand what tests, treatment and follow-up will be used to deal with your needs. Ask how you will get the results of the tests or the recommended treatment.

If the tests have come back negative or inconclusive, ask about further tests or treatment. You may want to do this even if the problem has disappeared, especially if it was severe.

You may reject any treatment that your PCP recommends, or question the basis for his or her opinion. It's your body and your insurance. Health care providers are your advisors, not your superiors. You may want to ask your provider for a second opinion.

If your problem persists, don't hesitate to call your provider. You should not have to wait long to see the health care provider.

Don't be afraid to be a "squeaky wheel." Your carrier has contracted with you to provide coverage for services and it's your right to get what was promised.

Take the time to read and understand your plan's grievance procedures. Some people are afraid they'll be labeled a "complainer" for disagreeing with the doctor or insurance company. Remember, you are entitled to the services in your contract. Don't be afraid to fight for them if you're treated unfairly.

How to deal with billing problems

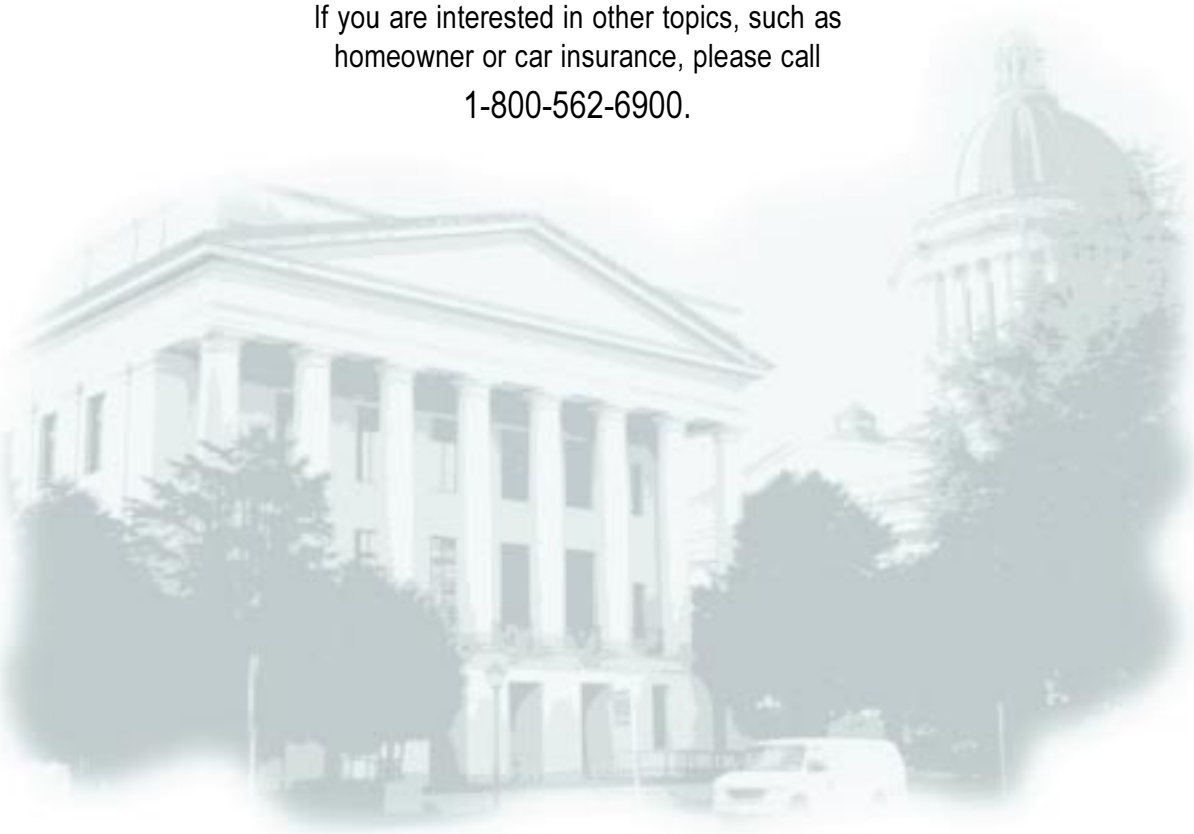
Check over your bills or invoices. If you don't understand them, call the carrier's assistance line (the telephone number should be listed on your statement). Remember that you may be responsible for co-pays on some services and/or prescriptions.

Wait for your carrier's statement **before** you pay your provider directly.

Example: Jonas Y. was referred by his PCP to a specialist about his bunions. After his visit, he received a bill from the orthopedist for $313. He mistakenly paid this bill. A month later, he received a statement from his insurer that the allowed charges were $242 and that "Total Patient Responsibility" was $71. Jonas can now ask the specialist for a refund, but he could have avoided the problem in the first place by waiting to see what he owed.

Call for help!

If you are confused or have a problem, call our office for help:
1-800-562-6900.

This Consumer's Guide is one of a series
prepared by the Office of the Insurance Commissioner.
If you are interested in other topics, such as
homeowner or car insurance, please call

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