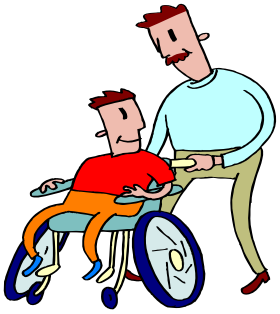
Getting the Best Out of Managed Care, #1

How can this information help me?

The health care system in the U.S. has gone through a lot of changes in the past few years. Sometimes it is hard to know how the system now works. You may have trouble deciding which type of health care is best for you. We often have to choose between health plans that look alike at first.

These five fact sheets will try to help you understand how the system works and how to choose the best health plan for you and your family. First, we will explain a little about the health care system. It's important to know how the system works so that you will know what kinds of questions to ask. We'll also explain some of the terms that you will need to know. Next, we'll tell you about the different ways that health plans get graded. If you know how the grading is done, you can tell better which health plan is best for you and your family. We will help you find information you'll need to choose a health plan wisely.



How does the U.S. health care system work?

In many countries, the national government has a health care system that covers everyone in the country. This is called "universal health care" because everyone has health insurance. When a person needs health care, she shows the health care provider her national health card, and the government pays for the health care with tax money.

In the U.S., we have a combination of government and private health care insurance programs. For low-income people, the federal and state governments operate the Medicaid program. The Medicaid program provides health insurance for many people who are working, but earn little money, and for many people who are retired or not able to work. People who receive SSI benefits automatically receive Medicaid in most states.

The Medicare program is a health insurance program for the elderly and for many people with special needs. A person does not need to have a low income to receive Medicare. Some low-income, elderly people or people with special needs have both Medicaid and Medicare.

For people with a little higher income, every state has a State Children's Health Insurance Program or SCHIP. Each state has a different name for its SCHIP program. Both the federal and state governments pay for this program. In most states, the SCHIP program covers only children, but some states now cover parents too.

Some states have their own programs for certain groups of people. A state may have a special program for children with special needs or for people with certain types of conditions or illnesses. Some states have programs for people who are "hard to insure" because they have an illness or condition that is costly. Some states have special programs to cover immigrants who otherwise would not be eligible for public health care programs.

People who are working and who are not eligible for these programs often can get insurance through the workplace. The employer usually pays all or part of the cost of the private insurance. A person may or may not have a choice of plans.

Even with all of these programs, millions of Americans do not have health insurance. For people who have no insurance, many local governments, like counties, offer some kind of medical care. The county may pay for the care if the person has no income, or the county may send her a bill. Without health insurance, a person must pay for health care out of her own pocket.

What is "Managed Care?"

It used to be that if you had health insurance, you went to the doctor of your choice, and if the doctor took your insurance, the insurance paid for the services based on what the doctor did for you. This is called **fee-for-service** or **indemnity**.

Today, most people with insurance must get their health care through a managed care health plan. When you sign up for a health plan, the health plan will often call you a **member** of the plan.

The term "managed care" actually covers a lot of different kinds of health plans, but most managed care plans have certain things in common. With many managed care health plans, you usually have to go to one of the doctors on the health plan's list. Only the doctors on that list have agreed to be part of that plan's **network**. To be on the list, those doctors have agreed to limit what they charge for their services.

Over the past few years, health care has become more expensive. Managed care is supposed to keep down the costs of health care by cutting out "unnecessary" services. Sometimes you and your plan may disagree as to what is a necessary service. If you have this disagreement, you should file a grievance with your plan. (See Fact Sheet #2) People who have Medicaid or Medicare also have other options to appeal.

What are some types of managed care?

One of the most common types of managed care organizations is a Health Maintenance Organization or **HMO**. These are also sometimes called Prepaid Health Plans or **PHP**s. An HMO usually provides a wide variety of services, both for people who must be in the hospital ("in-patients") and for people who visit a doctor then go home ("out-patients"). The HMO will have contracts with doctors, hospitals, and other health care providers to give services to the HMO's members. The health care providers are paid a set amount of money for each member, no matter how many times that member sees the provider. This is called a **capitation payment**. Except for emergencies, an HMO usually does not pay for services which are provided by a health care provider outside of the HMO network.

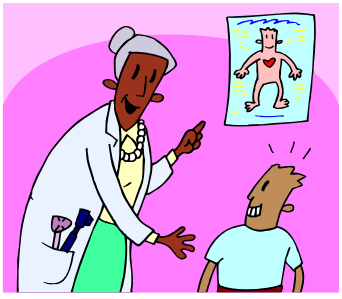
A managed fee-for-service plan is another type of health insurance plan. A managed fee-for-service plan will pay the providers a certain amount of money for each office visit or for each service that the provider gives to a patient. The plan will look at how often services are used and other ways to cut down costs. This is called **utilization control**.

What do PPO and POS stand for?

Another type of managed care organization is a Preferred Provider Organization or **PPO**. Providers in a PPO network discount their fees to members of the PPO. In a PPO, you can use doctors who are not in the plan's network. However, using a health care provider in the PPO's network will cost you less than using one who is not in the network. PPOs sometimes use case managers to reduce costs and coordinate a patient's care.

Point of Service or **POS** plans are similar to HMOs, but you can choose to use a doctor out of the network. However, if the doctor is not in the network, you will probably have to pay a good part of the cost out of your own pocket.

What is a "Primary Care Provider?"



Under many managed health plans, you will have a **primary care provider**. This is the doctor, nurse practitioner, or physician's assistant to whom you often have to go *first* when you need medical help. Usually, you cannot decide on your own to go to a specialist. If you need a specialist, your primary care provider usually has to refer you to the specialist. If you just go on your own without the

doctor's referral, the health plan may not pay for the specialist's services.

> ***Be the Smart Consumer:*** If you have the need to see a specialist regularly, some health plans let you make the specialist your primary care provider. *Ask your plan.*

What are co-payments and premiums?

A **co-payment** is the part of your medical care that you have to pay. For instance, a health plan may pay for your medication, but you will have a $10 co-payment. That means that when you go to the pharmacy for your medication, you will have to pay $10 out of your pocket.

A **premium** is the amount that you pay each month or each quarter to keep the health insurance.

Why should I know what kind of managed care plan I have?

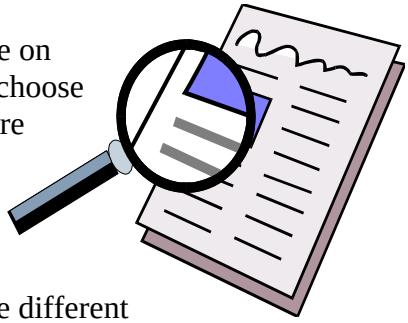
The type of plan you have determines which doctors you can see and what the services will cost you. If you have an HMO, you must see the doctors in the HMO network. On the other hand, if you have a PPO or POS, you may be able to see doctors who are not part of the network. If you stay inside the plan's network, it will usually cost you much less than if you go outside the network for services. If your health plan does not include the services or providers that you need, it may cost a lot of money to get the services outside of the network or the plan.

These issues can be important for deciding which plans offer the services that your family needs.

> ***Be the Smart Consumer:*** If you have a true medical emergency, the managed care plan **must** pay for the emergency services, even if your primary care provider did not refer you. You should read your benefits booklet to understand how your plan expects you to handle emergencies.

What if my family has Medicaid?

Medicaid is a health insurance program for low-income people. The federal and state governments jointly run it. If your family is low-income, you should check with your local public assistance office to see if you might be eligible for this program.



Many people who are on Medicaid must now choose between managed care programs. Many families receiving Medicaid will receive packets of information about the different managed care plans. Using the information in these fact sheets, you should be able to make a better choice about which plan is right for you.

For people with special needs, some states allow you to receive Medicaid benefits without having to be in a managed care plan. If you have a special need and you do not want to be in a managed care plan, ask your eligibility worker, case manager, or enrollment broker whether you can get an exemption from having to enroll in managed care.

What if we are asked to choose a Medicaid managed care plan but we do not choose one?

If you do not choose a plan, the state will usually choose one for you. This is called **default** or **automatic enrollment**. Sometimes people are put into a plan and they do not know it until they go to the doctor. If your doctor is not in the new plan, you may need to change doctors or change health plans. If you are "automatically enrolled," you often can change plans within 30 days after you are enrolled. (In some states, like New York, you may have up to 45 days to change plans.) There are often limits as to when and how often you can change plans.

What if I receive Medicare?

If you have Medicare, you may also have a choice to go into a managed care plan. This is called **Medicare Advantage**. You should read these fact sheets to understand your choices.

What is "Quality Information?"

Have you had to choose which health plan you wanted? How did you choose? What if you had information that told you which health plan does a better job of providing health care? The information that tells you which plan works better would be the **quality information**.

Quality information tells you how well a health plan provides health care to its members. The information tells you how well a health plan does things like provide service quickly or provide the treatments that people need.

Where does quality information come from?

The information on quality is put together in several different ways. Many health plans do **surveys** of their members. A survey asks the members many questions about the services they receive. The plan then puts the answers together to show how well the plan is doing. Some states, employers, and consumer groups also do surveys. You should read Fact Sheet #5 to learn more about consumer surveys.

Quality information also comes from **performance data**. This is information, usually numbers, which shows how well the health plan does on things that are being measured. Performance data might show how many children are tested for hearing problems or how many people with diabetes have complications from the diabetes. Fact Sheet #2 explains more about performance data.

For quality information, you would also look at **enrollment** and **disenrollment** information. In other words, you would look to see how many people are signing up for the plan (enrollment) and how many people are leaving the plan (disenrollment). If a lot of people are enrolling in a plan, it may mean that it is a good plan, but it also could be because the plan just became available in new areas. Are a lot of people disenrolling? If so, they may be unhappy with the plan. Fact Sheet #2 explains more about enrollment and disenrollment.

Audits and **reviews** can be important to look at for quality too. Government agencies and some private agencies look at the records of health plans. They may look at the financial records and also the health records of patients. Is the plan losing money? Is the plan spending its money on patient care or on executives' salaries? Compare the amount of money spent on administration to the amount spent on care. At the end of Fact Sheet #2, we suggest some places to get audit and review information.

Most health plans try to get **accreditation**. This means that an agency looks at how well the plan is doing. The agency will rate or grade the plan. If the health plan meets the agency's standards, then the agency will approve the health plan. The agency may be a private agency or a government department. In some states, plans may need certain kinds of accreditation in order to stay in business. Keep in mind that plans often pay money to the private agencies that offer accreditation.

Another important factor to look at is the number of grievances. A **grievance** is a formal complaint that you make against a health plan when you disagree with the plan's actions. Does the plan have a lot of grievances? If so, then maybe it is not serving the patients well. If a plan does not have many grievances, it may mean that the plan serves its members well. On the other hand, maybe the plan does not tell its members how to file grievances, so

nobody does. Be sure to read Fact Sheet #2 for more information on this subject.

Who puts together quality information?

Quality information comes from a lot of different places. There are some government agencies that put together quality information. There are also private agencies that put together the information.

> ***Be the Smart Consumer:*** Always look to see who has put the quality information together. Is it an association of health plans? If so, are they more interested in the consumers' needs or in making their plans look good?

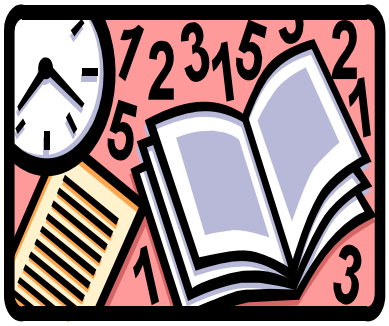
Some agencies put together information that is nationwide; other agencies look at state or local plans only. Nationwide data can give you good information on large health plans that operate in several states. However, even if the health plan is doing well nationwide, maybe it is not as good in your area. Local and statewide information will vary, depending on where you live. Find out whether your state has an agency or department that regulates health plans. Does that office publish quality information?

The information in this fact sheet will tell you a little about some of the organizations that put out quality information. The next fact sheets will tell you how to get that information and how to use the information.

What are some private organizations that put together quality information?

The National Committee for Quality Assurance (**NCQA**) is a national, nonprofit organization. The NCQA offers accreditation to HMOs and develops ways of measuring plans' performance. Originally, some health plan associations set up NCQA, but NCQA is now independent. However, NCQA still is at least partially funded by health plans. The NCQA developed a set of measurements of health plans called **HEDIS** (pronounced: Heé-diss). HEDIS looks at a number of things about a plan to see how well the plan performs. NCQA also uses the HEDIS information to put together a couple of report cards. NCQA has also developed standards for accreditation of managed care organizations that provide behavioral health care.

The Joint Commission (formerly **JCAHO**) (pronounced: jáy-co) accredits PPOs and HMOs. The Joint Commission also accredits hospitals. The Joint Commission puts out performance reports for the organizations that it offers accreditation.



Many large companies have become very concerned with the cost of health care for their employees. To try to keep down the costs of employer-provided insurance, these companies have formed various state or regional "business groups on health" to look at ways to measure the quality of the health care they are buying, reward good health plan practices, and pressure poorly performing health plans to improve.

Some private companies are also putting together quality information to make reports that you can buy online.

What managed care business groups put together quality information?

The American Association of Health Plans (**AAHP**) represents health plans like HMOs and PPOs. The AAHP puts out a *National Directory of Health Plans* and a *National Directory of HMOs* that can give you contact information about health plans.

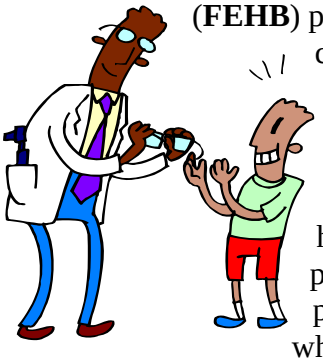
Are there U.S. government agencies that put together quality information?

There are several federal agencies that look at quality information. The Centers for Medicare and

Medicaid Services (**CMS**) is the agency that regulates the states' Medicaid programs. (Before June 2001, CMS was called HCFA.) While CMS regulates the plans that provide services to people with Medicaid, CMS also buys services from plans to provide services to people with Medicare. CMS's main office is in Baltimore, Maryland, but it has nine regional offices around the country. CMS puts out reports about Medicaid managed care.

The Agency for Healthcare Research and Quality (**AHRQ**) (pronounced: ark) is the federal agency that works for more research on quality information. AHRQ puts out a survey called **CAHPS** (pronounced: caps). Many plans are starting to use the CAHPS survey to find out how well the plans are doing their jobs. This agency used to be called the Agency for Health Care Policy and Research (AHCPR).

The Federal Employees Health Benefits Program (**FEHB**) provides health care coverage to federal employees, their families, and retirees. FEHB offers several different plans to its members. To help members decide which plan is best for them, FEHB provides the *FEHB Guide*, which is a report card on the available plans. Even though the *FEHB Guide* is for federal employees, it can provide helpful information for others.



The U.S. General Accounting Office (**GAO**) does research for Congress to look at how well your tax money is being spent. The Office of Inspector General (**OIG**) of the U.S. Department of Health and Human Services (**HHS**) investigates and enforces federal laws concerning health plans. The GAO and the OIG do not put out information on quality. However, if you want to see reports about managed care and quality information, these two agencies have these reports.

Be the Smart Consumer: Reports of federal and state agencies are almost always public information. Your tax dollars paid for the report. Don't let someone tell you that you cannot see the reports. Your Congressperson or Senator may be able to help you get a copy of a report. Although you may still need to pay for a copy, many reports are free and available on the Internet.

Are there state agencies that put out information on quality?

Each state regulates health plans differently. In some states, a department of corporations regulates all corporations, including health plans. A department of insurance or department of health may regulate the health plans. Some states now have departments of managed care that only look at managed care health plans. Some states have strong regulations, other states have very little regulation.

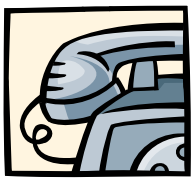
If you are not sure what department regulates health plans in your state, you can find out in a couple of different ways. You can look for the Web site for your state. The Web site could link you to the right agency. Most telephone books have a section at the front for state listings. Look through the listings to see if one is listed as regulating managed care health plans. Look in the newspaper for articles about managed care health plans. Does the article say something about your state's agency that regulates these plans? If you cannot find a department that regulates health plans, call your state legislative representative. Your state representative's office should be able to tell you what state agency or department to contact.

Contact your state's agency for regulating managed care health plans.

Be the Smart Consumer: Ask the state agency what consumer information about health plans is available. If the agency does not provide consumer information about health plans, ask why it doesn't.

Your state may also have managed care trade associations or other groups that publish managed care quality information for your state. You might also look at your state's medical association, consumer groups, state employee benefit plans, or the state Medicaid agency. Organizations like Family Voices that work with people with special needs may also know where you can find quality information.

Making Contact:



NCQA
1100 13th St., NW, Suite 1000
Washington, DC 20005
(202) 955-3500
www.ncqa.org
You can look at which plans NCQA accredits. You also can look at health plan report cards and other health quality information.

National Health Law Program
www.healthlaw.org
Our Web site offers some consumer information about civil rights and quality of health care. You will also find information to link to other consumer resources. There are also fact sheets about choosing a Medicaid or Medicare managed care plan:
http://www.healthlaw.org/library/folder.71020

SCHIP Programs
http://www.insurekidsnow.gov/index.htm
(877) 543-7669
This U.S. Department of Health and Human Services Web site has information about the SCHIP programs that each state has to provide health care coverage for children.

The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
(800) 994-6610 (Complaint hotline)
(630) 792-5000 (General questions)
www.jointcommission.org
You can make complaints about health care organizations or find out whether an organization is accredited. On the Web site, you can also learn about complaints made against an organization or get performance reports of organizations that The Joint Commission accredits.

OIG
Office of Inspector General,
Office of Public Affairs
Dept. of Health and Human Services
Room 5541, Cohen Bldg.
330 Independence Ave. SW
Washington, DC 20201
1-800-447-8477 (OIG Hotline)
(202) 619-1343
paffairs@oig.hhs.gov
http://oig.hhs.gov/
General Web site
http://oig.hhs.gov/oei/oeisearch.html
This webpage allows you to search for OIG reports on various subjects.

Families USA
1201 New York Ave., NW, Suite 1100
Washington, DC 20005
(202) 628-3030
www.familiesusa.org
The Web site has a resource list and information clearinghouse for various health care issues. For information specific to your state, click on the "State Information" link on the left of the homepage.

Family Voices
2340 Alamo SE, Suite 102
Albuquerque, NM 87106
1-888-835-5669
(505) 872-4774
www.familyvoices.org
The Web site has much useful information on managed care for families of children with special health care needs.

Federation of Families for Children's Mental Health
9605 Medical Center Drive, Suite 280
Rockville, MD 20850
(240) 403-1901
www.ffcmh.org
The FFCMH works with families with children with mental, emotional, or behavioral disorders. The organization also produces brochures on managed care for families with children with special needs.

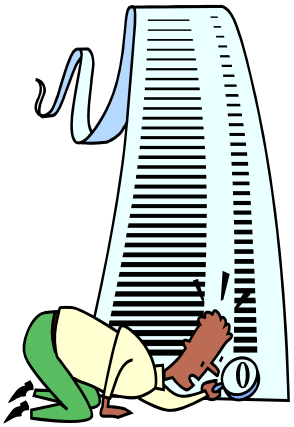
HealthCareCoach.com
www.healthcarecoach.com
This nonprofit Web site can help you understand managed care and health insurance. The Web site's articles can help you take control of your health care costs and get the health care that you need.

CMS
www.cms.hhs.gov
To contact by phone, check your telephone book under U.S. Government offices, Health and Human Services Department for your CMS regional office. CMS has some reports on Medicaid managed care for children with special needs. At the CMS Web site homepage, search under "children managed care."

The Center for Health Care Strategies (CHCS), in Lawrenceville, NJ, provided funding for "Making Sense of Managed Care Quality Information for Consumers with Special Needs." This project was made possible through a separate grant to CHCS by The Robert Wood Johnson Foundation. Annual revisions to this fact sheet were made possible by a grant from The California Endowment.

Fact Sheet #1 is one of five fact sheets on managed care for consumers. If you have trouble finding copies of the other fact sheets, please visit the National Health Law Program's Web site at: http://www.healthlaw.org/link.cfm?7727 *to download your free copies.*

National Health Law Program 2008



Having trouble finding this information?
Take this fact sheet to your local library that has computer access to the Internet. Ask the librarian to help you find this information on the Internet.