Healthcare Advocates, Inc

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Learn what makes health plans different

Compare plans and costs

Get the answers you need to make educated decisions

Selecting A Health Plan

for you and your family

A Message from the President

In the last twenty years, we've seen tremendous changes in healthcare—wonder drugs, laser surgery, DNA research—and it just keeps growing with each fantastic new discovery. While we've seen great changes in treatment, we've also seen great changes in the way we go about getting treatment. There are more insurance options than ever before—and lots to know before you decide which one is best for you.

At *Healthcare Advocates* our goal is simple—to get you the very best healthcare possible, no matter what kind of insurance you choose. We realize, however, that insurance plays a great role in your healthcare. For this reason, we've created this booklet to provide straightforward facts about the different kinds of plans—from HMOs to PPOs to indemnities, Medicare, Medicaid and more. You'll learn the basics of each one, including advantages and drawbacks, as well as answers to commonly asked questions. We've even provided a handy worksheet you can use to help you evaluate different plans before you make a decision.

Healthcare Advocates is committed to ensuring the healthcare you receive is the best it can be. Please remember, however, that this booklet is intended to serve only as a guide and should be read in conjunction with your health insurance benefits booklet. Also, we suggest that whenever you are considering a change in your insurance coverage, you consult your human resources representative, insurance representative, and physician. All of these people play a vital role in your care. It is important to know and explore all of your options, prior to making any changes. *Healthcare Advocates* assumes no liability whatsoever for the actions you make as a result of the information contained in this booklet.

We hope you find this information helpful, and as always, when you have questions, just call. *Healthcare Advocates* is your ally in healthcare.

Sincerely,

Kevin Flynn
President

Glossary

Term	Definition
Capitation	A payment method used by some HMOs to reimburse providers. Under capitation, providers are given a monthly fee based on the average patient's medical needs.
Ceiling	The ceiling is the maximum out-of-pocket expense a person is required to pay for their healthcare prior to the insurance plan paying 100% for all further treatments. Note: Often there are limits on total insurance expenditures, generally between $1 million and $5 million. The insurance company's obligation ends after it reaches the specified limit.
Copay (coinsurance)	The patient's share of the cost. Depending on your health plan, you will be responsible for either a percentage of a charge or a flat fee.
Deductible	The portion of your medical expenses for which you are responsible prior to coverage beginning. The deductible for a family is greater than that for an individual.
DMO	Dental Maintenance Organization.
Formulary	A list of drugs approved for use by a hospital or health insurer.
Gatekeeper	The gatekeeper is another name for a Primary Care Physician. See "PCP" in this glossary.
Grievance	The process by which a person may dispute denial of benefits or claims with their insurer.
HMO	Health Maintenance Organization.
Hospice	A pain management and care facility for the terminally ill.
HR	Abbreviation for the human resources department.
In-network	The providers that are part of your HMO, PPO or healthcare network.
Indemnity	The "traditional" health insurance plan in which providers and patients split costs according to a predetermined ratio (e.g., 80/20).
JCAHO	Joint Commission on Accreditation of Healthcare Organizations.

Glossary

Term	Definition
Managed Care	A healthcare system where care is coordinated through a primary care physician. An HMO plan is considered the most tightly controlled "managed care" plan.
Medicaid	A joint federal and state health insurance program for those at or below poverty level.
Medicare	A federal insurance program for people age 65 and over, and for the disabled.
MediGap	A supplemental form of health insurance for Medicare participants.
NCQA	National Committee for Quality Assurance—a non-profit company that evaluates and accredits HMOs.
Out-of-network	Healthcare providers that are not a part of your HMO, PPO or healthcare network.
Out-of-pocket	The portion of payment for which the patient is responsible.
PCP	Primary Care Physician. The physician who is responsible for coordinating a patient's healthcare, also referred to as the "gatekeeper."
PHO	Physician Hospital Organization. Physicians and hospitals share resources to keep costs down. PHOs can contract with HMOs and PPOs to provide care for their members. Depending the state, they may compete as a healthcare insurer.
PPO	Preferred Provider Organization. A healthcare system that combines aspects of traditional indemnity plans with HMOs.
Pre-Existing Condition	A condition or ailment a person has prior to joining a health plan.
Provider	Any hospital, doctor, nurse, clinic, etc. providing treatment or diagnoses.
Skilled Nursing Staff	A nurse or staff of nurses with specific skill sets.
Specialist	A physician who specializes in a particular type of medicine (e.g., a neurosurgeon). This person is generally not your primary care physician.
UCR	The usual, customary and reasonable (UCR) rates are used by insurance companies to compensate providers for the services they perform.

Types of Plans

Insurance Overview

While different insurance plans and types of plans operate differently, they all have similarities. Some of these similarities include:

- copayments, also known as coinsurance
- limits on coverage
- exclusions (e.g., cosmetic surgery, experimental treatments, etc.)

The purpose of this booklet is to describe the different types of health insurance plans, how they operate, and how you can use this information to choose the best healthcare insurance plan for you and your family.

Health Maintenance Organizations (HMO)

Health Maintenance Organizations, also known as HMOs, use Primary Care Physicians to coordinate your healthcare. This physician, sometimes referred to as the "gatekeeper," is responsible for all of your care—from simple sniffles and broken arms, to physicals, wellness screenings and other common ailments. When you experience symptoms or problems outside the primary care physician's area of expertise, your primary care physician refers you to a specialist for care. The specialist—a surgeon, obstetrician, cardiologist, etc.—treats you from that point on, however, the specialist reports back to the primary care physician to ensure everyone is working together for your healthcare needs.

The primary care physician serves as a central resource for your medical and health history. The philosophy is that a central physician who has access to all of your medical needs can best coordinate each recommended procedure and treatment, taking into account your past medical experiences. It is not the intention of the primary care physician to limit access, however, it is their responsibility to see to it that each patient's care is appropriate.

Under other types of insurance plans, patients often refer themselves to specialists for a broad range of reasons without the doctor receiving the benefit of full medical records. Self-referral can cost the insurance company a great deal of money, not to mention time lost to inappropriate therapy. The HMO model helps better direct care and control costs by negotiating costs for these services and ensuring that expensive medical tests and treatments are used appropriately.

Office visits with your primary care physician generally run between $5 and $25. Your cost for a specialist referral can range from $0 to $35. Generally, there are no deductibles and no pre-existing clauses. In addition, once you begin treatment all your needs are covered.

HMOs are a great option for many, especially because they include benefits such as low-cost doctor visits, low-cost specialist care, and preventive care plans. The primary drawback, however, is selection. As an HMO member you are expected to obtain all of your healthcare through one of the physicians in the plan. In addition, you are generally restricted to receiving care in the hospitals that are part of the plan. For many, choice is crucial, but as HMOs continue to evolve, some of those issues

are diminishing. For instance, if your doctor is not part of the managed care plan being offered, you have several choices. You can select one of the doctors in the plan, or you can ask your doctor to become part of the plan. Many HMOs are inclusionary, meaning they welcome doctors into their network, provided they meet credentialing criteria. The good news is that as HMOs grow in popularity, more and more doctors are becoming affiliated with one or more of the plans. There are even some programs where the HMO will pay for care outside the network if it can be shown that the best care for treatment exists elsewhere.

Another primary complaint from HMO members is access to care. HMO members must obtain a referral from their primary care physician (PCP) before seeing a specialist. If you fail to obtain a referral you will most likely be responsible for the specialist's bill yourself. The good news here is that some HMOs are instituting direct access care for specialists such as OB/GYNs and optometrists. Rather than seeing a primary care physician first, patients can make their appointments directly with these specialists.

Emergency room visits are another complicated area for some HMO members. Your HMO provider will publish a list of certain emergencies such as uncontrollable bleeding, loss of consciousness, severe pain, high persistent fever, etc. Under those circumstances, you are to proceed to the nearest medical facility regardless of its affiliation with your healthcare plan. Most plans ask, however, that you notify them of the emergency situation within 24 hours of its occurrence. Failure to contact the HMO may result in denial of coverage if the problem turns out to be a non-emergency matter. Problems not listed on your emergency listing require you to call your health plan prior to entering the emergency room. However, HMOs are supposed to judge your case by your symptoms, not the ultimate diagnosis. Contact your HMO for details on your plan.

HMOs have several operating models:

Staff Model: This HMO hires physicians to work on a salary-plus-bonus basis at the HMO's clinic or hospital. The physicians will generally see only HMO patients at this facility.

Group Model: This HMO contracts with different physician groups whose physicians generally see only HMO members. The physician groups own the offices and clinics.

Individual Practice Association (IPA): This HMO contracts with private practice physicians who agree to see HMO members along with their other patients. The IPA model is currently the most popular and is growing in comparison to other HMO models.

Network Model: This HMO contracts with two or more independent group practices. The practice group agrees to see the HMO's members along with their other patients.

Whether an HMO uses a staff, group, individual or network model is not particularly important to clinical quality. Studies indicate that a person's satisfaction with an HMO is generally based upon their satisfaction with their primary care physician. No matter which plan you select, be sure you are happy with your primary care physician.

Pluses of HMOs

• HMOs generally have less expensive monthly premiums than other plans. Copays are minimal and deductibles generally do not exist.

• HMOs generally do not have pre-existing conditions clauses.

• Because HMOs operate on the principle of preventive health, they often have health and wellness programs such as: health club programs, stress management, flu shots, smoking cessation and weight control programs.

• Your primary care physician coordinates all of your care through referrals and communicates with the other treating physicians.

• Because HMOs have no deductibles and minimal copays, the more you need healthcare, the more money you save.

• HMOs are trying to create a paperless system. Because of this there is very little paperwork and if you pay your copay at the time of their visit, you should never receive a bill unless you go out-of-network. Some are even eliminating the paper referral system. They electronically forward your chart to the treating physician.

Minuses of HMOs

• As a member of an HMO your selection of doctors is restricted to those listed in your HMO benefits manual.

• Prescription plans are generally limited to the medications listed on your HMO's formulary. Your physician can facilitate your HMO covering other medications if he or she determines the need.

• If you want to use a doctor or hospital that is not on your HMO's list, you will need special authorization or you will be responsible for the bill yourself.

• HMOs generally request that you contact them prior to going to the emergency room if your symptoms do not fall within the their definitions of an emergency. Failure to do so may result in the HMO denying payment of the emergency room bill.

• Different HMOs deal with issues of illness outside their service area differently. For example, if you were to become sick while visiting your mother in a different state, you may be responsible for some of or the entire bill. Your HMO benefits manual will list your responsibilities.

• If your children are covered under your policy and go away to school, be sure that the plan, or the school's plan, covers them wherever they reside during the school year.

Point of Service Plans (POS)

Some HMOs offer a Point of Service (POS) plan. A POS plan is an HMO plan with the option to use out-of-network providers. If you use in-network providers, the plan works like an HMO and you will have a low copay and use a primary care physician. If you choose to go out-of-network, you will generally be responsible for a deductible and 20% - 30% of the physician's bill and any charges above your insurance company's UCR rate.

Preferred Provider Organizations (PPO)

Preferred Provider Organizations or PPOs are a unique combination of a traditional indemnity plan and an HMO plan. You receive the cost benefits of an HMO while getting the freedom of choice offered by traditional indemnity plans. When members choose doctors and benefits within the network, their plan works like an HMO (with regard to cost). If you choose to see another physician or specialist outside of the network, you will be responsible for a portion of the bill and the insurance picks up the rest once the deductible has been met. PPO members have open access to medical care, but also benefit from their PPO's pre-negotiated contracts.

When you join a PPO you will receive a PPO directory guide. This guide contains all of the providers who are part of your PPO's network. The PPO's network consists of physicians, hospitals, laboratories and clinics that have agreed to provide services for the PPO's members at a set fee. Because the providers have agreed on a set fee, the cost savings are passed along to you as lower premiums and deductibles. Most PPOs don't have in-network deductibles, however, most have them for out-of-network care.

While you are given incentives to use providers in your PPO network you may use out-of-network providers. If you choose to see a physician or use a hospital outside the PPO network, you will be responsible for a greater deductible and copay—and in some instances, the amount over the usual and customary rate. Generally, a PPO has an individual (as opposed to family) out-of-network deductible between $250 and $500, and your cost increases from a $5 to $25 copay, to 20% to 30% of the physician's bill.

Example: If you are treated by an in-network provider you pay $5 to $25 per visit. If you choose to use an out-of-network provider, you must first meet the out-of-network deductible, and then you will be responsible for 20% to 30% of the physician's bill, and any charges in excess of the UCR fee schedule (depending on the plan). As you can see, you may use an out-of-network provider, but it costs more.

PPOs, like other types of insurance, have out-of-pocket "ceilings." These ceilings are designed to insure that individuals and families are not placed in financial hardship if a family member becomes ill and incurs large medical

bills. Because PPOs allow you to use both in-network and out-of-network providers, they generally have two different ceiling limits.

Out-of-pocket expenses are generally unlimited because most office visits and treatments have such small copays ($5 - $25). If you choose to obtain care from out-of-network providers, the out-of-pocket ceiling is generally between $1,000 and $2,500 for an individual and $2,000 and $5,000 for a family.

Pluses of PPOs

• Copays are generally a minimal charge unless you use an out-of-network provider.

• PPOs generally do not have deductibles for in-network providers. Deductibles for out-of-network providers generally run between $250 – $1,000 for an individual and $500 – $2,500 for a family.

• PPOs allow you to access any provider in their network at anytime. There is no "gatekeeper" though a small list of procedures require pre-authorization from the PPO. Check your policy for a listing of these procedures.

• PPOs are a unique combination between traditional plans and HMOs. They allow you access to a wide variety of providers and tend to be less expensive than traditional plans.

• PPOs have out-of-pocket ceilings. These ceilings range between $1,000 and $5,000 for out-of-network providers.

Minuses of PPOs

• Your selection of physicians is restricted to those listed in your benefits booklet. If you decide to use a physician outside your plan, you could be responsible for a greater percentage of the bill.

• There is generally an out-of-pocket deductible, and you are expected to pay for doctor visits at the time of treatment, if you want to use a provider outside of the PPO network.

• Different PPOs deal with issues of illness outside their service area differently. For example, if you become sick while visiting your mother in a different state, you may be responsible for some of or all of the bill. Your benefits book will list your responsibilities.

• If your children are covered under your policy and go away to school, be sure that your plan, or the school's plan, covers them wherever they reside during the school year.

• PPOs generally have pre-existing conditions clauses.

Traditional Plans (Indemnity)

Traditional plans, also known as Indemnity plans, are the plans most of us grew up with. When covered by a traditional plan, your access to physicians, hospitals, clinics and care is generally determined by you. Along with open access to medical care, you are generally entitled to other benefits like a prescription plan, durable medical equipment and specialized nursing, though you will need a prescription for these items. You have the freedom to see whom you want, when you want.

Traditional plans operate on the basis of deductibles and reimbursements. The philosophy behind this is simple. You are responsible for a portion of the services you choose and use. Because you are required to pay a portion of the bill you will only seek treatment when it is truly needed. This helps keep people from seeing a doctor for every sniffle and cut they encounter.

Traditional insurance companies require you to pay an annual deductible ranging from $100 to $1,000, depending on the plan, prior to coverage commencing. Once you have met your deductible, the insurance company will reimburse you on a percentage basis. The reimbursement rate is commonly an 80/20 split. That is, the insurance company pays for 80% of the medical expenses and you are responsible for the other 20%. Some doctors require you to pay the entire office visit fee at the time of service and others submit bills to your insurance company, on your behalf, and you pay only your copay. Check with your doctors to see how they operate. Note: you may also be responsible for any charges in excess of the insurer's UCR fee schedule. Be sure to ask your physician if his fee meets the usual and customary fee schedule.

Traditional plans, like other plans, have out-of-pocket ceilings for individuals and families. These ceilings are generally between $3,000 and $10,000.

Pluses of Traditional Plans

- Traditional plans give you the freedom to see any doctor or use any hospital, anywhere, at anytime.
- Traditional insurance generally pays 80% of your medical bills, once you have met your annual deductible.

Minuses of Traditional Plans

- Traditional plans tend to have higher monthly premiums and copays than other types of health plans. You are generally expected to pay for services at the tine of treatment and submit claims forms for reimbursement.
- Because traditional plans allow you to be seen by any physician, they do not have any review or credentialing procedures.
- Traditional plans generally have pre-existing conditions clauses.

Self-Insured Plans

Americans generally acquire their health insurance through their employer and the majority of Americans are covered by self-insured plans. While your company may be self-insured, to you there is no significant difference. Self-insured employer companies generally contract with health insurance companies or third party administrators to administer the benefits of the plans to their employees. If this is the case, you generally fall into one of the health plans discussed in this booklet.

Employees covered by self-insured companies have one distinct advantage over non self-insured companies. The advantage is advocacy. If you have a problem with your health plan, your employer has a greater ability to help resolve the problem. However, self-insured plans are not subject to state insurance laws and employers may choose to add or delete certain types of coverage without regard to state mandates on insurance companies.

Medicare

Medicare is a federal insurance plan designed to insure people who are disabled or who are age 65 and over, and have either paid into Social Security or are eligible for entitlements under a current or former spouse. Medicare has two parts—"Part A" and "Part B". Part A generally pertains to your hospital and institutional benefits, while Part B pertains to your non-hospital benefits.

Medicare Part A

Medicare "Part A" covers medically necessary hospital care, skilled nursing facilities, psychiatric hospitals, rehabilitation and hospice care. Medicare's coverage is defined by a "benefit period." A benefit period begins the first day you receive medical treatment from a qualified hospital, hospice or skilled nursing facility, and ends when you have been out of the facility for 60 consecutive days.

If you enter a facility again after 60 days, a new benefit period begins. If you re-enter the hospital within the 60-day period, you are considered to be receiving care as part of the original benefit period. With each new benefit period, all "Part A" hospital and skilled nursing facility benefits are renewed except for "lifetime reserve days*" or psychiatric hospital benefits that are used. There is no limit to the number of "benefit periods" you can have for hospital or skilled nursing care.

* Each Medicare recipient has 60 lifetime reserve days that may be used when the recipient chooses to use them. A lifetime reserve day is an extra day of coverage that is allotted when the Medicare recipient chooses (see chart on next page).

Summary of Medicare (Part A) Coverage: 1997

Services	Benefit	Medicare Pays	You Pay
Hospitalization	First 60 days 61st to 90th day 91st to 150th day* Beyond 150 days	All but $760 All but $190 a day All but $380 a day Nothing	$760 $190 a day $380 a day All costs
Skilled Nursing Facility Care	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $95 a day	Up to $95 a day
	Beyond 100 days	Nothing	All costs
Home Healthcare	Unlimited as long as you meet Medicare conditions	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
Hospice Care	For as long as a doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care	Limited costs for outpatient drugs and inpatient respite care
Blood	Unlimited during a benefit period if medically necessary	All but first 3 pints per calendar year	For first 3 pints per calendar year

Medicare Part B

Medicare "Part B" covers medically necessary physician services, outpatient services, physical and occupational therapy, speech pathology, X-rays, laboratory tests and home healthcare if you declined "Part A."

Coverage also applies to certain ambulance services and durable medical equipment. Outpatient prescription drugs are not covered under "Part B."

Each year you are responsible for a $100 deductible. Once the deductible is met, Medicare "Part B" generally covers 80% of the Medicare approved amount for all medically necessary care. The "Medicare Approved Amount" is based on a nationwide fee schedule. This schedule assigns a dollar amount to every service a physician performs based on a number of criteria. If a physician, or other provider, charges more than "Medicare's approved amount," you are generally responsible for the difference. Be sure to ask if your physician or other provider accepts Medicare as payment in full (a/k/a "accepting assignment from Medicare"). If he or she does not, you are responsible for the portion of the bill above Medicare's approved rate.

Summary of Medicare (Part B) Coverage: 1997

Services	Benefit	Medicare Pays	You Pay
Medical Expenses	Unlimited if medically necessary	80% of approved amount (after $100 deductible) Reduced to 50% for most outpatient and mental health services	$100 deductible, 20% of approved amount and all charges above the approved amount
Clinical Laboratory Services	Unlimited if medically necessary	Generally 100% of approved amount	Nothing for services
Home Healthcare	Unlimited as long as you meet Medicare conditions	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
Outpatient Hospital Treatment	Unlimited if medically necessary	Medicare payment to hospital based on hospital cost	20% of billed amount (after $100 deductible)
Blood	Unlimited if medically necessary	80% of approved amount (after deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount for additional pints (after deductible)

Costs and Accessing Care under Medicare

As a recipient of Medicare you are entitled to all the benefits of "Part A" free of charge. You are entitled to these benefits because you or your spouse has paid into Social Security over the years. As a recipient you also are eligible to receive benefits under "Part B" though you must pay a monthly premium. In 1997 the premium was $43.80.

Accessing care under Medicare is much like accessing care under traditional insurance plans, provided that you have both "Parts A & B." Access to physicians, hospitals, and clinics is generally determined by you. Along with your open access to medical care you are entitled to benefits like durable medical equipment and specialized nursing though you need a prescription for these items.

For more information on Medicare, eligibility, entitlements and limitations contact the Medicare hotline at (800) 638-6833.

Medicare Supplemental Insurance (MediGap)

Medicare Supplemental Insurance is designed to fill the gaps in Medicare's coverage. This supplemental insurance begins where Medicare leaves off. Here is an example: the supplemental insurance pays the initial deductible and daily in-hospital copay for which you are responsible. It also covers the cost for additional blood, medical equipment, etc.

There are many different types of Medicare Supplemental Insurance. The basic plans cover your "Part A" deductibles and copays if you become hospitalized. The mid-level plans cover your "Part A & B" deductibles, copays, skilled nursing staff and at-home recovery benefits. The higher-level plans cover your "Part A & B" deductibles, copays, skilled nursing facility, at-home recovery benefits, a prescription plan and coverage for preventive care. Of course with additional coverage come additional premiums.

On the next page is a chart of the 10 standard Medicare supplemental plans (MediGap). Plan "A" is the "basic" MediGap plan, and the chart increases in the plan's coverage up to plan "J" which is the most comprehensive and expensive plan. On the left-hand side of the chart is a list of benefits. There is a check-mark in the column of every benefit covered under the 10 plans.

Standard Medicare Supplemental Plans (MediGap)

Plan ➜	A	B	C	D	E	F	G	H	I	J
Basic Benefits										
Part A Hospitalization (days 61-90)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Lifetime Reserve Days (91-150)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
365 Life Hospital Days-100%	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Part A & B Blood	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Part B Coinsurance-20%	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Additional Benefits										
Skilled Nursing (days 21-100)			✔	✔	✔	✔	✔	✔	✔	✔
Part A Deductible		✔	✔	✔	✔	✔	✔	✔	✔	✔
Part B Deductible			✔			✔				✔
Part B Excess Charges						100%	80%		100%	100%
Foreign Travel Emergency			✔	✔	✔	✔	✔	✔	✔	✔
At-Home Recovery				✔			✔		✔	✔
Prescription Drugs										
Preventive Medical Care					✔					✔

Medicare HMOs

Medicare HMO plans are “wraparound” plans that incorporate traditional Medicare benefits with supplemental insurance and utilize an HMO provider network.

As a member of a Medicare HMO you will access care the same way an HMO member would. You are generally assigned a primary care physician (PCP) and gain access to general and specialty care through him or her. You also may be responsible for contacting your HMO prior to being treated in an Emergency Room. Failure to do so could cause the HMO to deny coverage for non-emergency visits. For more information on HMOs read the section on HMOs in this booklet.

If you become a member of a Medicare HMO you must continue to pay your “Part B” premiums to Medicare. You are still part of Medicare, but your benefits are obtained through the HMO, not Medicare. The benefits of joining a Medicare HMO are no deductibles, more comprehensive benefits (e.g., well visits, prescription plans, etc. are included in the plan) and smaller copays (generally between $0 and $25).

Medicare HMO plans have different plan levels and payment schedules. Standard coverage may cost between $0 and $50 a month. Superior plans that provide greater benefits and lower copays, may cost between $10 and $100 a month. Again, it depends on the plan you choose.

You are not alone if you wonder whether you should join a Medicare HMO or stay on traditional Medicare. To help you decide, ask the physicians and hospitals in your area. Your local physicians and hospitals have daily experience with all of the health plans in your area and should be able to help you make an informed decision. If you join a Medicare HMO, and later decide that you want to switch back to traditional Medicare, you can. All you have to do to return is to send a letter to the Medicare HMO or the Social Security office asking to be disenrolled. In 30 to 45 days you can expect a notice that you have been disenrolled from the HMO. From that point, you no longer receive your benefits from the HMO, but from Medicare itself.

Medicaid

Medicaid is a joint federal and state health insurance plan for the poor, children, the blind and the disabled. Each state has considerable flexibility in how it structures its Medicaid system, so each state's system is different.

Generally, Medicaid coverage includes:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Medical and surgical services of dentists
- Laboratory and X-ray services
- Nursing facility services (age 21 and over)
- Home Healthcare (age 21 and over)
- Family planning services and supplies
- Rural health clinic services
- Federally qualified health center services
- Nurse-midwife services
- Pediatric services and nurse practitioners
- Outpatient prescription drugs
- Assurance of the availability of necessary transportation
- Early periodic screening, diagnostic and treatment services for children under age 21 and treatment for conditions identified in screening

You cannot select Medicaid as a health insurance plan. It was designed to help a specific population segment. To be eligible for Medicaid you must qualify under your state's guidelines. If you are interested in learning more about Medicaid contact your local welfare office.

Several states now require Medicaid recipients to join a Medicaid HMO. Other states offer it as an alternative to Medicaid. Members of a Medicaid HMO plan access care through the Medicaid HMO, just like any other HMO member. For more information on how to access care under an HMO, read the section on HMOs in this booklet. For more information on your state's Medicaid program, contact your local welfare department and ask for the Medicaid intake person.

Commonly Asked Questions

Where do I get information on health insurance plans?
There are many places to get information on health insurance:

• Ask your physician's office and local hospitals which plan they would recommend based on your health needs. Your physician and local hospitals see many patients and know how each plan works with its members.

• Contact the departments of health and insurance in your state and ask if there are any complaints against the plan. If so, what kind of complaints? Make sure you are given a meaningful statistic; the larger the plan, the more complaints one may expect. Ask for the number of complaints per 1,000 members.

• Ask the Human Resources representative at your company which plan they recommend and why.

• If you are thinking of joining an HMO, ask the HMO if it has been accredited, what level of accreditation it has received, and by whom.

• Ask your colleagues, friends and family about their experiences.

One of the most common statements *Healthcare Advocates* hears is, "if I knew that I wouldn't have joined that plan!" Be proactive in selecting a plan. Prior to changing your plan make sure that you have read and understand the new plan, its benefits, limitations and exclusions.

When can dependents be added or removed from my plan?
During your company's annual open enrollment period you may add dependents to your health plan. In the case of a birth, the new family member may generally be added immediately. Be sure to follow your plan's instructions. You may remove a dependent from your plan at any time during the year.

I have a pre-existing condition and I am afraid to change jobs because I (or my child) will lose coverage.
Don't be afraid. In 1996 the federal government passed the Health Insurance Portability and Accountability Act (HIPAA). This new law is intended to help prevent "job lock" which occurs when a person would like to change jobs but does not for fear of the pre-existing condition clauses in many health insurance plans.

If you have participated in (been covered by) your present employer's insurance plan for a minimum of 12 months and change jobs, your new employer's insurance plan must cover your pre-existing conditions.

Though this new law allows you to change jobs without fear of the pre-existing conditions clause, you are still subject to the conditions and limitations: of your new employer's insurance policy. Here is an example of HIPAA's limitations. Let's say you were utilizing the mental health benefits of your old plan, and you changed jobs only to discover

that your new plan does not include mental health benefits. In this situation, the new law cannot help you. So, be sure that your new employer's insurance plan has the benefits you need prior to changing jobs.

Another note on HIPAA: if there is a significant lapse in coverage, a lapse being any period greater than 63 days whereby you are not covered by the employer's plan, the HIPAA law may not be enforceable. Please contact your Human Resources Department for further details.

What is COBRA?
The Consolidated Omnibus Budget Reconciliation Act, "COBRA," law was enacted in 1986 and provides for continuing a person's or family's group health insurance when employment has been terminated from an employer with over 20 employees.

COBRA simply states that when an employee leaves an employer, the "employee" may continue his or her health insurance under the employer's group health plan. The full cost of the premiums and deductibles are the responsibility of the ex-employee. After terminating employment, there is a 60-day window of time in which the ex-employee must make the first payment to the former employer.

Coverage under COBRA lasts for 3 years, unless you lost benefits because of termination of your job (fired or laid-off) or your work hours were reduced. In those situations you are entitled to 18 months of coverage. The 18 months may be extended to 36 months if other events like death, divorce or separation occur during the 18-month period. COBRA is fairly complex. You should seek advice if your situation is not clearly set forth in the law.

The rights of spouses and dependents under COBRA:
If you are a spouse of an employee, you have the right to choose continuation of coverage for yourself in the event you lose coverage for one of the following reasons:

- Death of your spouse
- Termination of your spouse's employment or reduction in work hours
- Divorce or legal separation
- Your spouse becomes entitled to Medicare

In the case of dependent children, they have the right to continue coverage if coverage is lost for any of the following reasons:

- Death of a parent
- Termination of parent's employment or reduction in work hours
- Divorce or legal separation of parents
- The parent becomes entitled to Medicare
- The dependent child ceases to be a "dependent child" under the insurance plan's regulations

What is a Pre-Existing Condition?
A pre-existing condition is when you are diagnosed with a condition (or if a reasonably prudent person would have sought medical advice for symptoms he or she has been having) prior to being accepted by a new health insurance company. If you are

diagnosed with a condition, your health insurer holds the right to deny coverage for the ailment or condition for a set period of time, or may increase your premium rate. The time period could be from several months to a year depending on the insurance plan.

HMOs, because of the way they are designed, generally do not have any pre-existing conditions clauses. Some non-federally qualified HMOs, like most other insurance plans, do reserve the right to deny coverage based on your application. Basically, if your application is accepted by an HMO, they will generally cover you and any pre-existing conditions.

I have had the same insurance plan for years. Can they drop me now that I have been diagnosed with a chronic ailment?
No. In order for your existing insurance company to drop you they must first prove one of the following:

1. Material misrepresentation. This is when you misrepresent yourself to the insurance company. An example would be answering "no" to the question, "have you been diagnosed with cancer?" when, in fact, you have been.

2. That the condition pre-existed the policy inception date (the date the policy started).

The only other way an insurer may limit or cancel your policy is if you:
- Fail to pay your premiums
- Lose your job and fail to extend your coverage under COBRA
- Become eligible for benefits under another plan that is considered to be your primary insurer

What are the common exclusions from health plans?
The following is a general listing of exclusions. Some of the items listed may be covered by your plan and/or your plan may have additional exclusions. Because there are so many different insurance providers and types of plans, we cannot list exclusions plan by plan. Please read your benefits manual for details on your health plan.

- Cosmetic surgery
- Routine foot care
- Experimental or investigative procedures
- Alternative treatments
- Assisted fertilization techniques
- Circumcision
- Radial keratotomy or corrective myopia
- Contraceptives
- Vision care
- Weight reduction programs
- Dental care
- Private duty nurses
- Injuries sustained while committing a felony
- Military or occupational injuries
- Treatments which were not pre-authorized
- Hearing aids
- Medically unnecessary treatments

What is a Flexible Spending Account (FSA)?
There are two kinds of Flexible Spending Accounts—one for healthcare expenses and one for dependent care expenses. If your employer has them, you may participate in one or both.

The healthcare FSA allows employees to designate a fixed amount of money to be deducted from their salary and placed into their FSA each month. The money placed in the FSA is pre-tax but must be used during the calendar year.

What is pre-tax money?

Pre-tax money is money taken from your wages that is not taxed and, in effect, lowers your total income earned and subsequently your taxes. Example: If an employee makes $30,000 a year, he or she is taxed on $30,000 and is still responsible for deductibles, copays, eyeglasses, etc. If the same employee put $2,000 into an FSA, he or she only pays income tax on $28,000. He or she may then pay deductibles, copays and other healthcare-related expenses with the money in the FSA.

What is considered healthcare under a Healthcare FSA?

The following is a partial list of what is covered under a Healthcare FSA:

- Hospital care
- Care by doctors, dentists or registered nurses (including experimental treatments, cosmetic surgery, out-of-network physicians, etc.)
- Psychiatric and psychological care
- Prescription drugs
- Transportation to receive medical care
- Vision care including glasses and contact lenses
- Dental care including dentures and orthodontia
- Oxygen
- Deductibles and copays under your health insurance or dental plan
- Some FSAs will cover your health insurance premiums
- Miscellaneous expenses such as seeing eye dogs, hearing aids, medical equipment, prosthetic aids, etc.

In addition to the Healthcare FSA there is also a Dependent Care FSA. A Dependent Care FSA works the same way as a Healthcare FSA, but it covers the cost of caring for your dependents.

The following is a partial list of what is covered under a Dependent Care FSA:

- Nursery School
- In-home dependent care
- State licensed day care
- Baby sitting
- Camp expenses for children under 13
- If you have elderly parents, it may also be used to pay for their care.

What are the drawbacks to an FSA?

While FSAs allow you to put aside pre-tax money, be careful. Any money left in the account at the end of the year will be lost. Make sure you calculate your healthcare costs each year before signing up for your Healthcare FSA or Dependent Care FSA. For more information on Flexible Spending Accounts contact your Human Resources Department.

What is a Medical Savings Account (MSA)?

The federal government, under the Clinton administration, enacted Medical Savings Accounts. The accounts are designed to provide the self-employed with tax relief and more options in their healthcare needs.

Simply put, an MSA is a high-deductible insurance plan accompanied by a savings account to cover some amount of the higher deductible. Most traditional insurance plans have deductibles in the range of $250. An individual or employer using an MSA would purchase a catastrophic insurance plan with a deductible between $2,000 and $4,500. Families and individuals who incur large medical costs in a single year are financially protected by the catastrophic coverage. The premium for the higher-deductible policy is substantially less than for the low-deductible policy, and those savings are placed in an account that can be used for day-to-day healthcare expenses (e.g., doctor visits, prescriptions, etc). At the end of the year funds can be carried over to cover future medical expenses. Upon retirement, remaining funds can be used to fund a Medicare MSA or to purchase long-term care insurance.

What is the current status of Medical Savings Accounts?

Medical Savings Accounts are new and are currently in a demonstration stage. Congress allowed 750,000 people to open medical savings accounts in 1997. The purpose for the pilot project is to determine if medical savings accounts are beneficial to the public.

Because medical savings accounts are new, there are conflicts in legislation between certain states' tax codes and those of the Internal Revenue Service. If you have or are considering opening a Medical Savings Account, contact your state's Department of Revenue and ask if your state has a conflict with the tax status adopted by the Internal Revenue Service. If it does, it is possible that you may have to pay state income tax on the money in your medical savings account.

Voluntary Accrediting Organizations

The following organizations are independent organizations that rate healthcare plans and/or hospitals. When choosing a healthcare plan or hospital, ask if they have been accredited by one of these organizations and what rating they received.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

The JCAHO accredits hospitals, HMOs, PPOs, health networks, rehabilitation clinics and more. The JCAHO, an independent evaluator of healthcare organizations, accredits providers and insurers every 2 years and has 5 levels of accreditation:

Accreditation with Commendation
Full accreditation with a commendation to those facilities that demonstrate exemplary performance.

Accreditation
The facility complies with applicable standards.

Conditional Accreditation
The facility has deficiencies in one or more

areas. The JCAHO will monitor the facility's progress and reevaluate at a later time.

Provisional Accreditation
The facility has shown deficiencies in the first two surveys. Provisional Accreditation is granted until the JCAHO completes a full survey.

Not Accredited
The facility was denied accreditation, the facility withdrew from the accreditation process or the facility has not applied for accreditation in the past 2 years.

National Committee for Quality Assurance (NCQA)

The NCQA accredits HMO plans. They do not accredit traditional or PPO plans. NCQA accreditation is generally voluntary though some states do require accreditation. Because accreditation is not mandatory throughout the 50 states, not all HMOs have been evaluated by the NCQA. For those that have been accredited, there are seven accreditation categories:

Full Accreditation is granted for 3 years to those HMO plans which have excellent programs for "continuous quality improvement," and meet NCQA credentialing criteria.

One-Year Accreditation is granted to plans that have well-established quality improvement plans, and meet most of the NCQA standards. The NCQA provides the HMO with a list of recommendations and reevaluates the plan the following year.

Provisional Accreditation is granted for 1 year to HMOs that have an adequate quality assurance plan and meet some of the NCQA standards. These plans must demonstrate progress before they can obtain a higher level of accreditation.

Denial is given to those plans that do not have acceptable quality assurance programs and do not meet enough of the NCQA standards to receive another accreditation status.

Under Review is given to those HMOs which have been reviewed, but have asked the NCQA to reevaluate their decision.

Initial Decision Pending is given to an HMO that has been reviewed and is waiting for their NCQA rating.

Future Review Scheduled is given when a plan has requested a review, but the NCQA has not yet reviewed it.

Getting Good Healthcare

Everyone wants good, quality healthcare. To ensure this, you need to be proactive. How do you do this?

Take responsibility for your healthcare, educate yourself and know your responsibilities:

- Read your insurance documentation and know what your plan's benefits and limitations are.
- Ask questions! Contact the customer support number for your insurance plan and ask them all of your questions.
- Learn what pre-authorizations are needed prior to obtaining treatment.
- Find out if you need to contact your insurance company prior to going to the emergency room.
- Ask if your plan has a health club incentive/program.
- Ask your plan if they have smoking cessation, weight loss, prenatal and/or stress reduction programs.
- Find out what benefits are covered while traveling out of state and out of the country.

Do you and your physician have a good relationship? Here are some questions to ask yourself that give you an indication of the relationship:

- Can you get helpful advice from your physician by phone?
- How long must you wait for an appointment?
- Will your physician refer you for specialty care?
- Does your physician tell you test results and follow your progress?
- Does your physician explain what is wrong, what is being done and what you can expect?
- Does your physician spend enough time listening to you and explaining his or her treatment plan?

In addition to knowing your responsibilities and developing a relationship with your physician you must also understand your options.

- Get second opinions:
- Get the latest research on your conditions and treatments.
- Ask about drug interactions.
- Ask about invasive and non-invasive alternatives.
- Ask the doctor how many cases of "this type" he or she has treated.
- Ask for full explanations.
- Contact organizations like the American Cancer Society for information and support numbers.

Finding a Physician

There are several ways to find a good physician for your needs:

- Ask your family physician and other physicians who they recommend.

- Ask your colleges, family and friends who they recommend.

- Many hospitals have physician referral systems. These systems contain the physician's speciality, credentials, admitting privileges, etc. A listing of physician referral systems can generally be found in the yellow pages under "physicians."

- If you are part of an HMO, the customer support personnel should have a listing of each physician and his or her credentials. Some have developed easy-to-understand report cards.

- A good library might have a *Dorland's Medical Directory*. This directory contains the names, addresses and credentials of thousands of physicians.

Board Certified
If a physician is Board Certified it means that he or she has had an additional 3 to 7 years of specialized training and education, post residency, and has passed both a written and oral exam.

Fellowship
A resident who shows a high degree of skill and competence is sometimes asked if he or she would like to do a fellowship. A fellowship generally lasts one to three years and follows the completion of a physician's residency. It is additional, specialized training in a particular field of medicine. For example, a neurologist may do a fellowship in seizure disorders where he or she would spend a few years working solely with patients exhibiting seizure disorders.

Coverage and Features Comparison Sheet

Company Name	Sample	Plan 1 (fill in)	Plan 2 (fill in)
Plan Name	Sample Insurance Co.		
Monthly out-of-pocket premium	$ 220		
Type of Plan	PPO		
Annual Deductible	$250 individual / $750 family		
Plan pays for:			
$ or % of hospital stay (copay)	$20		
$ or % of office visit	$20		
$ or % of inpatient surgery	$20		
$ or % outpatient surgery	$20		
$ or % diagnostic services	$20		
$ or % prescription drugs	$10		
$ or % vision plan	$20		
$ or % dental plan	$20		
$ or % mental health plan	$20 outpatient		
Maximum annual out-of-pocket fee	$1,000 individual / $3,000 family, plus deductibles		
Other Services:			
Maternity	covered		
Routine checkups	covered		
Skilled nursing	40% of reasonable		
Home healthcare	40% of reasonable		
Other Features:			
Pre-existing conditions clause	if greater than 1 year		
How long is the rate guaranteed	6 months		
Plan recommended by your physician & HR dept. Yes/No	Yes		
Statistics:			
% of grievances	4%		
% ER denial rate	for HMOs only		
Profit or Non profit	Non profit		
NCQA or JCAHO rating	for HMOs only		

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