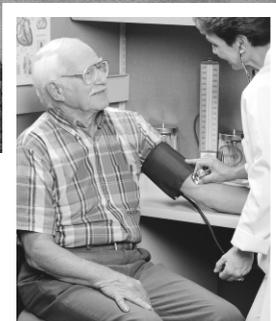


simple
A guide to
choosing
and using
a managed
care health
plan

Managed Care and You



This guide gives general information only. It does not give legal advice. After reading this guide, you may have more questions. Turn to the back cover for phone numbers you can call.

You can also get this guide in large print and braille and on audio tape and diskette. Call the Governor's Commission on Women at 1-800-881-1561 to ask for a copy. You can read it on-line at www.state.vt.us/wom

Please feel free to copy and share this guide.



Governor's Commission on Women
126 State Street, Montpelier, VT 05633-6801
1-800-881-1561 or 802-828-2851
e-mail: info@wom.state.vt.us
www.state.vt.us/wom

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	Look for this symbol throughout this guide to help you find useful phone numbers.
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About this guide

Why should I read this guide?

We talked to women in Vermont who are members of managed care health plans before we wrote this guide. They said one thing over and over: managed care changes the way you get health care. They gave us this advice: learn everything you can about managed care so you can avoid problems and get the care you and your family need. Reading this guide is one way to get the basic facts about managed care.

For more exact information about your own health plan, read your member handbook or call your plan.

Helpful Hints

Learn about managed care now to prevent problems later on.



What will this guide tell me?

Managed care is a whole new way of getting health care.

► Read this guide to learn about:

- how managed care works
- what you need to do to get the health care you and your family need
- what your rights are
- what to do if you have problems with your health plan
- how to be an active partner in your health care
- how to choose a health plan

How do I use this guide?

- Look for Helpful Hints that look like this  throughout this guide. These are useful tips for getting the most from managed care.
- Look on the back cover for phone numbers you can call for help and more information about managed care.
- Any words in **bold print** are explained in the *Glossary* at the end of the guide.

What is managed care?

What is managed care?

Managed care is a kind of health insurance where a **health plan** pays your bills and also provides your health care. The health plan arranges your care through its own **network** of doctors, hospitals, and other **health care providers**.

When you join a managed care health plan, you choose one doctor who will keep track of all of your health care. You get all of your care from the providers in your plan's network. **HMOs (health maintenance organizations)** are the best known type of managed care plan.

Managed care is very different from **fee-for-service** insurance. Fee-for-service is the way most of us are used to getting health care.

Today only a few people get to choose between managed care and fee-for-service. Most people are offered just one kind of insurance through their jobs or through a state program.

These are some differences between managed care health plans and fee-for-service.

Managed Care Health Plans	Fee-For-Service
<p>You can only go to providers who are in your health plan's network. If you go outside the network, you will have to pay extra.</p>	<p>You can go to any provider you choose.</p>
<p>You choose one doctor or nurse to arrange all of your care. This is your primary care provider (PCP).</p>	<p>You may not have a primary care provider who arranges all of your care.</p>
<p>You must get a referral from your primary care provider (PCP) before you can see a specialist (such as a skin doctor or a heart doctor) or use other services.</p>	<p>You can see a specialist without a referral.</p>

There may be trade-offs when you are in managed care.

When you are in a managed care health plan, you will have less choice of providers, but you may gain in other ways.

- ▶ **Some things people *like* about managed care:**
 - You pay very little out of your own pocket.
 - You can predict the cost.
 - You have less paperwork and few bills.
 - You have someone to help you arrange your health care.
 - You are covered for services like check-ups and shots that keep you well.

- ▶ **Some things people *may not like* about managed care:**
 - You have a limited choice of which doctors, hospitals and prescription drugs you can use.
 - You have more rules to follow if you want to see a specialist or get other services.

How to choose a health plan

If you have a choice between managed care health plans, you will want to choose the one that works best for you and your family. Think about which doctors and services your family needs. Then think about which plan can meet those needs the best.

Helpful Hints

Denise says:

“My son Danny goes to a special doctor for problems with his heart. The rest of our family is healthy. Our whole family had to join the same health plan. So we chose the plan that has Danny’s heart doctor in its network.”

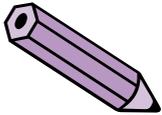


Turn the page for worksheets you can use to choose the plan that’s right for you.



Here are some questions to ask that will help you decide which plan is right for you.

Step 1 Ask yourself these questions:



- ✓ What are my health needs?

- ✓ What are my spouse's or partner's health needs?

- ✓ What are my children's health needs?

- ✓ Do we want to keep seeing the doctors and specialists we are seeing now?

Yes No

- ✓ Where do we like to go for:

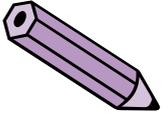
1. Hospital care _____

2. Pharmacy _____

3. Mental health counseling _____

4. Drug and alcohol treatment _____

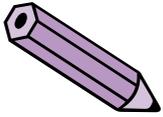
Step 2 Ask your friends, your family, and your doctors which health plans they like.





Step 3 Ask the health plans these questions:

(It may help to write down their answers as you compare plans.)



Plan A	Plan B
<i>fill in name of plan</i>	<i>fill in name of plan</i>

► special questions for women

1. How many ob/gyn (women's health) visits can I have without a referral from my PCP?	_____	_____
2. Can I use my ob/gyn as my PCP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

► questions about cost

1. How much will we pay for:		
– the premium	\$ _____	\$ _____
– office visits	\$ _____	\$ _____
– prescription drugs	\$ _____	\$ _____
– other services, like chiropractors	\$ _____	\$ _____
2. How much will we pay if we go outside the plan's network?	\$ _____	\$ _____

► questions about coverage

1. What services that we need:		
– are covered by the plan?	_____	_____
	_____	_____
	_____	_____
– are not covered?	_____	_____
	_____	_____
	_____	_____
– are only covered up to a certain point?	_____	_____
	_____	_____
	_____	_____

► **questions about doctors and services**

	Plan A	Plan B
	<i>fill in name of plan</i>	<i>fill in name of plan</i>
1. Are the doctors and specialists we see now in the plan's network?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. If our doctors are not in the network, which doctors close to home are taking new patients?	_____ _____	_____ _____
3. What pharmacies in the plan's network are close to home?	_____ _____	_____ _____
4. What hospitals can we use if we join the plan?	_____ _____	_____ _____
5. How long do we have to wait to get an appointment?	_____ _____	_____ _____
6. Does the plan have experts or special programs for special conditions my family has?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Can we still go to the same mental health counselor or drug and alcohol treatment program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

► **questions about quality**

1. What do its members think of the plan?	_____ _____	_____ _____
2. What does the plan do to improve quality?	_____ _____	_____ _____

Getting started in managed care

Getting started in a health plan

When you join a health plan, the plan will send you several important documents. Be sure to keep all of them!

▶ Member ID Card

- The member ID card shows that you are a member of the health plan. It also lists important phone numbers. ALWAYS carry this card with you and bring it to every medical appointment.

▶ Member Handbook

- The member handbook gives you a lot of information about how your health plan works, how to use it, and what your rights are. (If you are a member of Medicaid, VHAP, or Dr. Dynasaur, your member handbook also tells you what services your plan covers.)

▶ Provider Directory

- The provider directory lists the doctors, hospitals, pharmacies, and other health care providers you can use. This is your health plan's network of providers.

▶ Subscriber Contract

- The subscriber contract tells you exactly what services your health plan covers and any fees you will have to pay.

Helpful Hints

Rosa says:

“My plan sends me a lot of information. I started keeping all of it in a notebook. Now I can always find it when I need it.”



Choosing and using a primary care provider

The first thing you will do when you join a health plan is choose a **primary care provider**, or **PCP**, from the plan’s list of providers. The PCP is a doctor who you see first for most of your basic health care. In some health plans, you may choose a nurse or physician assistant as your PCP. Your PCP also arranges all of the care you get and keeps your records.

Choosing your primary care provider is the most important decision you will make in managed care. It is important to find one you feel good about. You have the right to choose a specialist as your primary care provider if you have a disability or other serious medical condition. If you don’t work well with your PCP, you can change to another one in your health plan’s network. Call your plan to find out how.

How to use your health plan

Learn what your plan covers

It is important to learn exactly what your health plan will pay for BEFORE you get care.

► **Read your subscriber contract (or, if you're a member of Medicaid, VHAP, or Dr. Dynasaur, read your member handbook) or call Member Services at your plan to find out:**

- what your plan covers
- what your plan does not cover
- what services your plan only covers up to a certain point

Helpful Hints

Sally says:

“Get to know your health plan’s Member Services Department! It’s their job to help you and answer your questions.”

Write their phone number here:

Member Services Department



When to call your primary care provider

- ▶ Call your PCP (primary care provider):
 - when you need a check-up or a shot
 - when you are sick or hurt
 - when you need prescription drugs
 - when you need a referral to see a specialist
 - when you need advice about health problems

Call for an appointment before you go to your PCP's office. Call 24 hours ahead to cancel your appointment if you can't make it.

Understanding referrals



You must get a **referral** (permission) from your PCP before you can see a specialist, go to the hospital, or have any x-rays or lab tests. ALWAYS ask if you need a referral before you get any other health care service. If your PCP refers you to a specialist (Dr. Brown) and Dr. Brown wants you to see another doctor (Dr. Green), you must go back to your PCP to get a referral to see Dr. Green.

Here are some important things to check every time you get a referral:

- ✓ Always make sure that the referral is for a service that is covered by your plan.
- ✓ Always make sure that the referral is to a provider in your plan's network.
- ✓ Always ask if there is a time limit on when you must use the referral.
- ✓ Always ask if the referral is good for only one visit or a series of visits.
- ✓ If you need to see a specialist often, ask for a **standing referral** so you won't have to go back to your PCP to get a new referral each time. A standing referral lets you see one specialist for a certain number of visits over a certain time.
- ✓ Ask for a copy of the referral.



You **MUST** call your PCP when you need medical care unless it's an emergency. If you decide on your own to go to another doctor or get any other services, your health plan **WILL NOT PAY** for your visit.

Helpful Hints

Mike says:

“Your PCP may not know your health plan’s rules very well. It’s a good idea to double check with Member Services at your plan to make sure your referral is okay.”



A special note about women’s health care

Women in Vermont have the right to go directly to their women’s health care provider (such as Planned Parenthood or a private ob/gyn) without a referral at least twice each year, plus follow-up on those visits. Some health plans will let you get this kind of care without a referral even more often than that.

Remember that the provider must still be part of your plan’s network.

What to do in an emergency

An **emergency** is a sudden illness or injury that can cause you serious harm or death if you are not treated right away.

▶ **These are some examples of emergencies:**

- chest pain
- broken bones
- rape
- very bad burns
- heavy bleeding
- poisoning

If you have an emergency, go directly to the emergency room or call 911. Call your plan as soon as possible to let them know.

Helpful Hints

Always try to follow your plan's rules for emergencies, but if you think your life or health is in danger, **DON'T WAIT**. Go to the emergency room right away.



What to do for an urgent problem

An **urgent medical problem** is a serious illness or injury that will not cause you serious harm or death if you wait a short time to see a doctor.

▶ These are some examples of urgent medical problems:

- vomiting
- sprained ankle
- earache

If you have an urgent medical problem, call your PCP. Describe how you are feeling. Your PCP will help you decide what to do. For urgent problems, a doctor will see you within 24 hours.

Helpful Hints

Jackie says:

“Make sure babysitters and family members know what to do if your kids get sick. I keep important numbers right by the phone.”



If you need care after hours

If you need care when your PCP's office is closed, call your PCP anyway. Your own PCP or a doctor on call will call you back. Together you can decide if you need to get care right away. This is not “bothering” your doctor. In fact, this is a very important part of how managed care works!

What to do if you are away from home

There may be times when you or your family get sick when you are outside of Vermont. You must follow your health plan's rules even when you are away from home.

Your plan will probably not pay for routine care you could have taken care of before you left home.

▶ **If you follow these steps, your health plan will be more likely to pay for care you need when you are away from home:**

- ✓ Always take your member ID card and your PCP's phone number with you when you travel.
- ✓ In an emergency, go to the nearest emergency room. Call your plan as soon as possible to let them know.
- ✓ For urgent problems, call your PCP for advice about what to do. Your PCP may give you permission to go to a doctor nearby.

Your health plan may treat a college student who lives away from home like the student is on a trip out of town. Before your child goes away to school, call both the college and your health plan to see what each of them will cover. Make appointments for routine doctor visits when the student will be home on break.

Helpful Hints

Karen says:

“When my kids play sports or go to camp, I always send along a copy of their member ID cards. I send the telephone numbers for their PCP and for our health plan, too.”



Prescriptions

When your doctor gives you a prescription, take your member ID card to a pharmacy that is part of your health plan’s network. Some health plans charge a fee for each prescription.

Many health plans have a list of prescription drugs they will pay for. You have the right to get a drug that is not on your plan’s list if your doctor thinks the plan’s drug is not working or might cause you harm.

Prevention—care to keep your family well

Preventive care is the “well care” your family needs to stay healthy. It includes things like shots, check-ups, Pap tests for women, and other tests. Most health plans cover preventive care. Many health plans also offer free classes to help you stay well, such as how to lose weight and how to quit smoking. Some plans even have a phone number you can call 24 hours a day to learn more about all kinds of health topics. Take advantage of all your plan offers!

How to use mental health and drug and alcohol treatment services

Mental health and drug and alcohol treatment services have their own rules.

In most health plans, you get mental health and drug and alcohol treatment services in a way that is different from other kinds of medical care. There may be a different set of rules for these services.

In most health plans, you don't have to call your PCP for a referral for mental health or drug and alcohol treatment services. Instead, you **MUST** call a special toll-free number. This number is written on the back of your member ID card. They will give you approval to see a provider on their list for a certain number of visits.

Your plan will only pay for visits to mental health and drug and alcohol treatment providers on their list. They will only pay for services they have approved.

Helpful Hints

Mona says:

“Be sure to use your plan’s special number to get approval for mental health or drug and alcohol treatment services.”

Write their phone number here:



Be active in your health care

Play an active role in your health care

Managed care is a business. Like any business, your health plan needs to cover their costs. To do this, they try to make sure you get only the care you need. So, health plans set limits on how much care and what kind of care you may use. This is why it is called managed care.

You and your health plan may not always agree about what they should pay for. To get the health care you deserve, it is important for you to play an active role.

► **Here are some things you can do to get the best care from your health plan:**

- Learn how your health plan works and follow its rules.
- Ask a lot of questions.
- Become a partner with your doctor in decisions about your health care.
- Speak up for yourself.
- Stand up for your rights.

Helpful Hints

Tom says:

“In managed care, you can’t be a passive patient! You’ve got to ask questions and know the rules. You’ve really got to speak up and get involved in your care!”



What to do when you have a problem

Speak up about problems like these:

- You have to wait too long for an appointment.
- Your doctor or your health plan won't give you a referral for care you think you need.
- Your doctor thinks you need a certain treatment, but your plan **denies** payment (will not pay).
- You get a bill you think your plan should pay.
- You are unhappy with your medical care.
- You think you will get better care from a specialist outside your plan's network.

How to get help with a problem

When you have a problem, always try to solve it using your health plan's own process for complaints and appeals. This is called a **grievance** process. If you are unhappy with their decision, you have the right to file an appeal outside your plan. You have the right to file a complaint or an appeal without fear of any effect on you.

Helpful Hints

When you call your plan about a problem:

- be prepared
- be pleasant
- ask questions
- take notes
- don't give up



Here are the steps you can take:

Step 1 Call the Member Services Department at your health plan. Tell them you want to make a complaint. They can solve many problems over the phone.



When you call:

- Always ask for the name of the person you speak with.
- Ask when you will hear back from them.
- Make notes about all of your calls to your plan, including the date of the call.

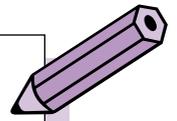
Keep copies of any letters you exchange with your plan. Keeping notes and letters will help if you decide to file an appeal.

Name of person you talked to: _____

Phone number: _____

Date of call: _____

Notes: _____



Step 2 If you are not happy with the response you get from Member Services, you have the right to file an appeal with your plan. If you have trouble writing your appeal, you can make your appeal over the phone or ask Member Services to help you put it in writing. Look on page 29 for a sample appeal letter.

If you are having an emergency or you need urgent care, you have the right to ask for an **expedited** (fast) appeal.

Step 3 If you are still unhappy with the plan’s decision, you can ask for a second review by the plan.

Step 4 If you are not happy with your plan’s final decision, you have the right to use the state’s **external appeals process**. This is an appeal you file outside your plan *after* you have gone through your plan’s appeals process. Call the Division of Health Care Administration at **1-800-631-7788**.



Helpful Hints

Bea says:

“You have the right to file a complaint with your plan any time you have a problem. If you don’t get what you want, you can appeal your plan’s decision. You have to ask for it, though. It won’t happen by itself.”



Other places to get help:



At any time, you can call the Office of the Health Care Ombudsman at **1-800-917-7787 (1-888-884-1955 TTY)**. This office is part of Vermont Legal Aid. They can answer questions about all kinds of health insurance, including managed care. They can help you with your complaint or appeal.



You can also call the Consumer Help Line at the Division of Health Care Administration at **1-800-631-7788**. This is a state office that looks into complaints about health insurance companies and makes sure they follow the law. This office also answers questions about all kinds of health insurance.

If you have problems with mental health or drug and alcohol treatment services:

- Call your health plan's special mental health and drug and alcohol treatment toll-free number. It is written on the back of your member ID card.
- You can file an outside appeal with the Independent Panel of Mental Health Providers *after* you have gone through your plan's appeals process. Call them at **802-828-3301**.



If you use Medicaid or Medicare, you have special appeal rights.



- If you are a member of Medicaid, VHAP, or Dr. Dynasaur, you have the right to appeal to the state. This is called a **fair hearing**. To ask for a fair hearing, call Health Access Member Services at 1-800-250-8427 (1-888-834-7898 TTY).
 - If you are in *Primary Care Plus*, you may ask the state for a fair hearing right away.
 - If you are in any other managed care plan, you must file an appeal with your plan first. If you are not happy with the plan's decision, then you may ask the state for a fair hearing.

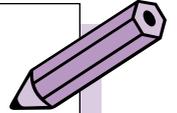


- If you are on Medicare, you have the right to appeal to the U.S. Health Care Financing Administration (HCFA). Call the HICA Program at 1-800-642-5119 for information and help. HICA is the Health Insurance Counseling and Assistance Program at the Vermont Area Agencies on Aging.

Note for Medicare users: After December 31, 1999, Vermonters on Medicare can no longer get their care from a Medicare managed care plan.

How to write an appeal letter

Send copies of any papers you think are useful, such as test results or a letter from your doctor, along with your letter. Use this sample letter to write your own.



Today's date

Member Services Department

Your Plan's Name

Your Plan's Address

To the Member Services Department:

My member ID number is _____.

I am writing to file an appeal with _____
name of health plan

I have already called (or written) the plan about this matter on _____
date but I did not agree with the response.

(Explain your complaint here. Include the dates and names of the people you have spoken to. Also explain why you did not agree with their response to your complaint. Clearly state what action you want your plan to take.)

I hope you will resolve this matter quickly.

Thank you.

Sincerely,

(sign your name)

print your name, address, and phone number here

Know your rights in managed care

You have certain rights when you join a managed care health plan in Vermont.

Information

- ▶ **You have the right to:**
 - have information about your plan and what it covers
 - ask questions and get information from your doctor about all of your treatment choices

Proper treatment without long delays

- ▶ **You have the right to:**
 - get services in a reasonable distance and time
 - get prompt treatment for emergency and urgent needs
 - have a “standing referral” to see a specialist
 - be treated with dignity and respect

Questions and complaints

- ▶ **You have the right to:**
 - be told, in writing, why you were denied treatment you and your doctor think you need
 - file a complaint or appeal with your plan about problems without fear of any effect on you
 - get a quick response to your complaint or appeal
 - file an appeal outside your plan

Care that meets your health needs

- ▶ **You have the right to:**
 - change your PCP
 - see a women's health provider at least twice a year without a referral
 - use your specialist as your PCP if you have a disability or serious medical condition
 - see skilled health care providers, including specialists, for the services your plan covers
 - ask to see a specialist outside of your plan's network if you cannot get the special care you need within your plan
 - get a prescription drug that is not on your plan's list if your doctor thinks the plan's drug is not working or might cause you harm

Meaning of terms

denial – When your health plan will not pay for a service or treatment.

emergency – A sudden illness or injury that can cause you serious harm or death if you are not treated right away. (Examples are chest pain, broken bones, and poisoning.)

expedited appeal – A fast appeal for emergencies and urgent care.

external appeal – An appeal you can make outside your health plan after you have gone through the plan's appeal process.

fair hearing – An appeal to the state of a health plan's decision, for members of Medicaid, VHAP, and Dr. Dynasaur.

fee-for-service – The way most of us are used to getting health care. With fee-for-service insurance, you can go to any provider you choose without a referral.

grievance – The term some health plans use for their complaint and appeal process.

HMO (health maintenance organization) – The best known type of managed care plan.

health care providers – Doctors, hospitals, and others who provide health care services.

health plan – In managed care, a health plan pays your bills and provides your health care.

managed care – A kind of health insurance where a health plan pays your bills and provides your health care. The health plan arranges your care through its own network of health care providers.

network – Doctors, hospitals, and other health care providers who agree to work with a health plan.

PCP (primary care provider) – A doctor who you see first for most of your basic health care. Your PCP also arranges all of the care you get and keeps your records.

preventive care – “Well care” your family needs to stay healthy.

referral – Permission from a primary care provider to see a specialist, go to the hospital, or have any x-rays or lab tests.

specialist – A doctor who has special training in caring for a certain part of the body or a certain disease. (For example, a dermatologist is a skin specialist and a cardiologist is a heart specialist.)

standing referral – Permission to see one specialist for a certain number of visits over a certain time.

urgent medical problem – A serious illness or injury that will not cause you serious harm or death if you wait a short time to see a doctor. (Examples are vomiting, earache, and sprained ankle.)

This guide was produced by the Women and Managed Care Initiative (WMCI) of the Governor's Commission on Women. The Women and Managed Care Initiative provides women with information and skills to help them understand and use managed care. This project is funded by a Rural Health Services Outreach Grant from the Office of Rural Health Policy, U. S. Department of Health and Human Services.

The Governor's Commission on Women works to improve the lives of Vermont's women and their families. The Commission provides information on issues such as family leave, health care, sexual harassment, and starting a business. The Commission works to create laws, policies and programs that help women. The Commission also advises state government and Vermont citizens about women's rights and needs.

We offer our thanks to the following organizations and agencies and for their help with our project:

Bi-State Primary Care Association
Blue Cross and Blue Shield of Vermont
Community Service Society of New York
Division of Health Care Administration, Vermont Department of
Banking, Insurance, Securities and Health Care Administration
Hardwick Patch
Kaiser Permanente
Lamoille District Office, Vermont Department of Health
Maximus
Mohawk Valley Plan
Office of the Health Care Ombudsman
Office of Vermont Health Access
Office of Women's Health, Vermont Department of Health
Southeast Vermont Community Action
Southwestern Vermont Council on Aging
Vermont Medical Society
Vermont State Employees Association

We are especially grateful to the dedicated members of the WMCI Collaborative Network for their hard work and support:

Central Vermont Adult Basic Education
Northeastern Vermont Area Agency on Aging
Vermont Adult Learning
Vermont Center for Independent Living
Vermont Low Income Advocacy Council
WIC Program, Vermont Department of Health



Useful phone numbers

For questions about Medicaid, VHAP, and Dr. Dynasaur

Health Access Member Services1-800-250-VHAP (1-800-250-8427)
(TTY) 1-888-834-7898

For help with problems

Health Care Ombudsman1-800-917-7787
(TTY) 1-888-884-1955

Division of Health Care Administration
Consumer Help Line1-800-631-7788

To file an appeal outside your health plan

Health Access Member Services
(for Medicaid, VHAP, and Dr. Dynasaur)1-800-250-8427
(TTY) 1-888-834-7898

Independent Panel of Mental Health Providers802-828-3301
(for mental health and drug and alcohol treatment services)

Division of Health Care Administration
(for all other managed care health plans)1-800-631-7788