Dealing with Managed Care

The huge growth of HMOs makes it likely that now or in the future you will be impacted by this new kind of healthcare delivery. Even if you keep the same doctor, under managed care she may be working under guidelines you are unaware of, created by the insurance company. Decisions about your care—time to spend on an appointment, what treatments to recommend or not to mention—can be based on guidelines determined by the HMO as to what is cost-effective for a large number of people in the aggregate rather than what is best in your individual case. Your doctor might alter how she practices without your even knowing it.

What is managed care?

Managed care is a catch-all term describing a system that combines coverage of health-care costs and delivery of healthcare for a prepaid premium. Instead of paying claims submitted by independent doctors or hospitals, managed care companies employ or have contracts with doctors and hospitals that set policies for what they can or can't do. For instance, they use an authorization process to limit access to specialists, cut down on self-defined unnecessary procedures, and reduce money spent on prescription drugs.

In the not-too-distant past, most patients had insurance that simply paid doctors and hospitals for treatment with no strings attached. This type of arrangement is called fee-for-service. You see the doctor of your choice, and he is free to prescribe treatments, drugs, or referrals to specialists without input from the insurance company. Managed care organizations, in contrast, try to keep costs down by controlling services. Managed care firms use a variety of methods to control costs.

- *Preventative services.* Most managed care companies emphasize prevention services (screening tests such as mammograms, counseling to stop smoking, providing childhood immunizations) to control costs. It is often cheaper to prevent future disease with lifestyle changes or minor interventions now, rather than pay for treatments later, so long as the same company will be paying the cost for an individual's healthcare throughout his life and that company is willing to act now for the financial long term.
- *Using "gatekeepers."* Primary care providers (PCPs) are the cornerstone of managed care. They deliver the majority of healthcare services needed by their patients. The theory is to coordinate all of the patient's care as well as to send patients to specialists only if it is truly necessary. However, in order to reduce costs, some HMO primary care providers are encouraged to manage conditions that may be beyond the scope of their training rather than refer patients to specialists. Many plans have financial incentives (rewards for keeping referrals to a minimum or punishments for too many referrals) to limit visits to specialists.
- *Limiting choice of doctor.* Patients who sign up with managed care organizations are required to choose a physician from a list of doctors who are employees or who have signed contracts to participate in the plan, follow its rules, and accept plan payments as payments in full for services. If your current doctor is not on the list, you'll have to switch to one who is. If your doctor is a member of the plan but later leaves, you will have to choose another doctor from the list.
- *Limiting choice of facilities.* Usually, managed care groups require patients to use specific hospitals and testing facilities. You may have to travel farther to get care from the HMO.
- *Limiting duration of hospital stays.* Laws have been passed regulating minimum stays after childbirth and outlawing "drive-through" mastectomies. But, for most surgeries, managed care organizations encourage doctors to discharge patients quickly to keep costs down.
- *Controlling drugs given.* Most managed care organizations have a formulary—a limited list of preferred drugs available at a reduced cost. Medications not on the formulary cost more for the patient, and the plan doctors are strongly discouraged from prescribing them.
- *Using utilization management.* Even though a service is listed as covered in the policy handbook, it may be denied by the group's utilization committee. The managed care firm develops

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"practice guidelines" and approves or rejects treatment based on these guidelines.

Remember, each type of health insurance has biases and weaknesses. Traditional fee-for-service tends to err on the side of doing too much for a patient, while HMOs err on the side of doing too little. HMOs' fixed budgets require that, if one patient is given more, someone else must make do with less. Managers, without a medical degree, may call the shots on your medical care. If you stay alert for these tendencies, ask good questions, and get the facts, you should be able to learn about all of the options and make informed choices.

Types of plans

There are variations on a few main themes in healthcare delivery. The four main types of programs are fee-for-service, independent practice associations, preferred provider organizations, and health maintenance organizations. They vary by who bears the risk of incurring costs and who decides what treatments are necessary.

Fee-for-service (unmanaged care)

The traditional type of insurance coverage most patients in the US are familiar with is fee-for-service private practice, in which the insurer pays the doctor for each visit or service. In this system, insurers are uninvolved third parties in the financial interactions between healthcare providers and patients. Patients go to the doctor of their choice, and the doctors treat patients as they see fit, without any oversight from the insurance company. Doctors spend as much time with each patient as they want, can order as many tests as they wish, and write prescriptions for the drugs they choose. Patients are free to hire and fire doctors, as well as go to the hospital of their choice. Approximately half of all insured Americans currently use fee-for-service insurance.

Prior to managed care, there were no incentives to contain costs. Healthcare costs spiraled up for decades, and the insurance companies passed the cost on to their policy holders by increasing premiums. The number of uninsured persons swelled. Costs of medical care rose dramatically, as did the incomes of doctors.

Today, most fee-for-service companies include managed care elements like pre-authorization for surgeries, precertification, utilization review, and sometimes formularies (lists of approved drugs).

Independent practice association (IPA)

An IPA is a group of independent, private practice physicians who have banded together in an association that contracts with various HMOs. The physicians agree to accept a set monthly fee per patient (capitation) in exchange for providing all medical care for HMO members. They are not compensated for the actual medical care given.

All of the risk moves from the insurers to the doctors and from a very large pool of people to a much smaller pool of people—those seen by a single practice. For instance, if one patient treated by the group needs a quarter-million-dollar kidney transplant, that could consume all of the profits for the year. In extreme cases (an unlucky year for patients) the doctor could go broke by giving his patients the care they need.

These flat fee systems encourage doctors to take on as many healthy patients as possible because they lose money treating patients with complicated or time-consuming illnesses. Capitation systems create a stark ethical conflict for doctors: treat patients and lose money. The threat of financial risk (or in extreme cases, insolvency) diminishes their ability to be caring and objective physicians.

Preferred provider organization (PPO)

A preferred provider organization is a type of health insurance in which a managed care organization contracts with private practice physicians to provide medical care for subscribers. The doctors accept lower fees and agree to controls on their work in exchange for increased patient volume. Thus, patients are steered to doctors with records of low-cost care. Subscribers can use a doctor who is not a preferred provider, but the PPO will pay a lower percentage of the bill.

Coverage and services vary considerably among plans. One mother of a child who required extensive medical services for years describes how well her PPO plan worked for her family.

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Health maintenance organization (HMO)
An HMO is a type of heath insurance in which the healthcare is provided by the insurer for a prepaid monthly premium rather than by independent physicians. These insurers are usually for-profit corporations that try to provide cost-effective healthcare through preventative medicine and limitations on service. They often hire their own doctors, whose salaries are often adjusted based on how effectively they keep costs down.

HMOs charge a small co-payment for each service provided, for example, ten dollars for each office visit and seven dollars for each prescription. Typically, there is no required deductible (a specific amount of money that is paid before insurance coverage begins).

The two most common types of HMO are staff and group. In staff model HMOs, all care provided to members is given at HMO facilities run by salaried doctors who are employees of the HMO or insurance company. In group model HMOs, service is provided by several groups of doctors who have contracted to care for members for a certain level of payment. These doctors are usually paid under a capitation arrangement.

Plans vary, and subscribers' feelings about them are varied as well.

Preventing problems

There are good reasons for the old adage, "An ounce of prevention is worth a pound of cure." It is far easier to prevent problems—especially in an ever-changing HMO environment—than to try to fix them. Assertive but friendly patients can forestall problems by taking a few basic precautions.

- Don't ever let coverage lapse.
- Pick the best plan and stay up to date on your policy coverage. Make sure you have all supplemental materials. Get a copy of the actual contract (the small print one) not the glossy booklets sent to plan members that provide few details. It is the actual contract itself that governs the plan, not the patient booklets. Evaluate how much you can or cannot get through the plan, how much your physician can or cannot do, and how restrictive the plan is overall.
- Pick the right doctor. If you find an ethical, compassionate doctor and you work to establish a good relationship, you will have far fewer problems. It is less likely that your caring doctor will succumb to pressure to give you inferior care if he has a good relationship with you. Ask the following questions: How are you paid by the HMO? Capitation? Salary? Are there any financial incentives that create ethical dilemmas for you? What would you do if I needed a referral to a specialist, and the HMO said no?
- Add a point-of-service (POS) option to your coverage. This allows you to go outside of the network (approved physicians and hospitals) if you get a serious illness and wish to see an expert not in the plan. The HMO agrees to pay a percentage of the fee from the outside expert (usually 70 percent after you pay a hefty deductible). For instance, if you need a kidney transplant, you may not wish to go to the small hospital in your HMO that has performed only a few such surgeries. Instead, you research the best facilities for kidney transplants, activate your POS, and get state-of-the-art treatment at a renowned transplant center. POS plans are more expensive than basic coverage. However, you buy peace of mind, knowing that you can get the best medicine has to offer should the need arise.
- Don't sign away your right to go to court. Some HMOs have arbitration agreements, in which you lose your right to go to court. Instead, you must go through an HMO-controlled arbitration process. If there is such a clause in the HMO contract, simply cross it out and initial it. If your employer has made such an agreement for his entire workforce, lobby to have that provision changed.
- Always ask if there are other treatment options available for you than those the HMO recommends. If your doctor or a utilization committee

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denies you treatment or referrals you think you need, or says no other treatment options exist, make them put the denial in writing.

- Be friendly with doctors, nurses, lab technicians, receptionists, and administrators. Even organizations with strict rules are run by human beings like you. Cheerful greetings and a smile will help the HMO workers see you as a person rather than another package on the assembly line. Friendliness makes it more likely that they will go the extra mile for you if the need arises.
- If you need a referral, procedure, or hospitalization, ask the doctor or hospital if they have any suggestions on how to make authorization easier. There are often key words to use—medical necessity, bad faith refusal, irreparable damage, not within the acceptable standards of care—that may get a quick response. The doctors may suggest strategies that they know from experience will work well.
- If you are referred to a specialist, make sure that the authorization has arrived at the specialist's office prior to your appointment.
- When you go for an appointment, decide in advance what you want, be clear and concise in your presentation, then be reasonable and persistent.
- Get your HMO doctor on your side. For instance, if you feel you need a specialist, but the quality of the specialists in the network is low, try to get the PCP to side with you that you need a specialist to handle your care. If the PCP cannot get you a referral outside the network, contact well-known specialists outside the network to try to convince the company's medical director that state-of-the-art care cannot be provided by on-staff doctors. Contact national organizations or famous institutions (Stanford, the Mayo Clinic, etc.) to see if they will recommend one of the top experts available for your problem. Then send a certified letter to the HMO medical director stating, "Dr. B., national authority on XYZ disease who works at the Mayo Clinic, recommends Dr. A. for neurosurgery."
- Take notes, a tape recorder, or a friend with you to appointments.
- Never stay in a hospital by yourself. Have a spouse or trusted friend present at all times when you are in the hospital, even if that means sleeping in a chair or on the floor. Hospitals are complex institutions, and with nurses and other professional caregivers being replaced in favor of low-wage, relatively untrained laborers, you may be unable to get the attention you require. If you're in a hospital, you may be medicated, or unable to get up easily from the bed. Having an advocate present to monitor what is given you, and to make sure you get the treatment you need, is essential. If something goes wrong, he or she can act quickly to get help.

Types of problems

Problems can arise with any insurance plan. Some of the problems most common with managed care organizations follow.

- Delay in getting an appointment.
- Short appointments.
- Gatekeeper won't refer to a specialist. This is one of the most common complaints lodged against HMO primary care doctors. HMOs strongly encourage primary doctors to handle most medical care themselves to keep costs down. This makes sense for garden-variety ailments—ear infections or bronchitis—but for people with a rare or life-threatening disorder, it can cause major problems.
- Doctors pressured to limit care.
- Specialists in network aren't the best for the problem.
- Restrictions on prescription drugs.

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- Difficulty getting authorization for emergency care. Some HMO subscribers also have difficulties getting their insurer to pay for emergency care if it occurred outside the network, for example, if you became ill on a trip.
- Limited hospital stays.
- Limitations on care.
- Refusal to pay for treatments deemed experimental by the HMO.
- Refusal to pay for care at noncontract facilities.
- Automatic refusals.

Solving problems

The types of problems encountered by patients in managed care systems range from having to wait weeks for an appointment to refusal to pay for emergency room visits. Each managed care organization has a complaint and appeals procedure to follow, and they are required to provide this information to you. Get a copy of your group's policies. Don't rely on the information given to you on the phone—you could waste precious time following the wrong rules. As one patient said, "One thing I learned in the HMO, you can't be a wimp."

Problems fall into two broad categories: grievances and appeals. Grievances are complaints about service, such as a rude doctor or waiting too long for an appointment. Appeals are a procedure used when the plan denies or terminates a service you think you need, or refuses to pay for care you've already received. To file a grievance with your HMO, take the following steps.

- Talk to the person with whom you had the problem to see if it can be resolved.
- Call the member services department and explain the problem. Make sure to write down the date and time, the phone number, and the first and last names of the person with whom you spoke. Keep a record of what was said and note the person's direct phone line number.
- If the problem is not resolved, write to the plan to ask for an investigation. Different states (as well as each plan) have varying amounts of time during which they are required to respond. To find out your state's regulations, call your state department of insurance.
- Call frequently to ask about the status of the investigation.

Take the following steps to begin the appeal process.

- First, make an appointment with your PCP to explain your problem and ask for help. For example, if the problem is refusal to refer you to a specialist, ask her for the reasons (medical and economic) why she refuses to refer you. Tell her clearly why you think the referral is necessary. You may just change her mind. One patient describes this technique:

  Here's what I do when my HMO refuses to do something I think I need. Let's say I have a lump in my breast I want biopsied, but the mammogram is negative. I want the biopsy, but the doctor says no. I whip out my pen and notebook and say, "I want to be sure I understand you correctly. You are saying you will not do a biopsy on this lump which has doubled in size over the last ten months, is that correct?" When he says yes, I tell him, "I will be writing a letter for your file containing that exact information." I'd send this letter to the head of the medical staff, the administrator, the local medical society, and anyone else who might be a big gun.

  I'd tell them what I want to happen, for example, "I want my biopsy by Friday the 23rd or I will have it done by an outside physician, and I will bill the HMO for all associated costs (including travel time)." I'd include my phone number, and give a specific time when I will call for their final decision. I'd send the letter by registered mail, so they have to sign for it and I get the receipt. It may be that the doctor is under orders not to do a biopsy without a positive mammogram. He may welcome

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me going toe to toe with the administration so he can do his job. He may not be the bad guy here.

- Your plan is required to notify you in writing about any denial, reduction, or termination of services. If you have not received it, ask for a written response explaining the medical and financial reasons for refusing the treatment or payment. Demand that the names of all persons involved in the decision, including any "medical advisors" and their qualifications, be included. You should also ask for articles from the medical literature that support the plan's position. If the administration can't or won't provide any, your case is strengthened. In the meantime, locate articles that support your position and attach them to your appeal.
- Take the written denial to your primary care doctor to ask him to write a letter of appeal on your behalf. For instance, if your doctor thinks you need a sophisticated diagnostic test, but the HMO refuses to pay for it, he might be willing to go to bat for you. If he refuses, try to get the plan to send you to another doctor in the network for a second opinion. If they refuse, or if you feel it is important to get an out-of-network view, pay for an independent second opinion yourself.
- Write a letter of appeal yourself and send it to the insurance carrier and your employment benefits manager. Send the letter by certified mail and get a receipt with the signature of the person who accepted the letter. The letter should include a clear and concise definition of the problem as well as your name, policy number, doctors' statements, lab results, and other pertinent materials. Make sure to state in the letter what action you want the group to take to resolve the problem. Don't delay writing the letter: your right to start an appeal may expire in as few as 30 days. Keep copies of all correspondence for your records. One doctor advises:

  There are two things that I emphasize when I talk to my patients. First, strive to keep the problem in the medical domain to the degree possible. Work to make your doctor your ally. Once you go to appeal, it becomes a contractual process, further and further removed from the human need. Second, I give people permission to challenge the authority of these decisions. The idea of appeal is really foreign to most people and very few actually appeal decisions, even when they clearly should.

- The appeal process begins when you write the letter asking for reconsideration of the HMO's decision. The plan generally must complete this reconsideration of their decision within 60 days. Keep calling to find out the status of the appeal. If you need an expedited appeal because your health could be in peril if you wait the 60 days, request it in writing, and enclose supporting documentation from a doctor.
- Consider hiring a medical claims assistance professional. She will organize paperwork, research appeals procedures, and gather medical reports.
- To go outside the HMO for help, send a copy of your written complaint and related documents to the state insurance commissioner as well as your local and state medical societies.
- Send your appeal to your state senators and representatives and your US senators and representatives. These elected officials have staff members who try to help their constituents. In addition, it helps them, as they ponder how to vote on healthcare-related bills, to know the struggles that members of managed care organizations sometimes face.
- If you are insured through your place of employment, contact the benefits department or union benefits manager to see if they will support your position. If enough problems arise, your company may threaten to find another healthcare plan, and this threat may help resolve your problem favorably.

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- Don't pay a bill that your insurance or Medicaid should pay, even if the claim is taking a long time going through the system and you are being hounded by collection agencies. Many public assistance programs like Medicaid have no provision for reimbursing you once you have paid. Keep your providers informed about your efforts to get payment. A lawyer suggests:

  > *People are afraid of ruining their credit rating, but it takes years for medical bills to hit credit reports. As long as an investigation is open, any adverse reports can be explained to creditors. There are federal laws—including the Fair Credit Reporting Act—which govern this.*

- If you still have the problem, tell the HMO staffers that you will go to the local and national press after a certain date if the problem is not resolved. Sometimes the threat of bad press will help, while other times it hurts.

- Contact Physicians Who Care, an advocacy group of more than 3,500 doctors. Call their complaint hotline: (800) 800-5154, and leave a message about any abuse or ill effects (denials of access to specialists or procedures, reimbursement problems, denials of needed treatments, etc.) resulting from your HMO care. They will contact you by letter within a week. All information is confidential.

- Contact a consumer advocacy group such as the Consumer Federation of America's insurance group at (202) 547-6426, or the Center for Patient Advocacy at (800) 846-7444 or on the Internet at *http://www.patientadvocacy.org*. Families USA provides a list of state agencies regulating healthcare and information on state managed care laws at (202) 628-3030 or *http://www.familiesusa.org*.

- Get a lawyer. Lawsuits can take years, and involve endless maneuvering. Most who go through the process say they underestimated how hard it would be, especially to relive the medical trauma. And then, of course, there is the possibility that you have a legitimate case but will be unable to prove it in court, or state laws may limit your right to collect. Nevertheless, legal help may be your last chance to get the care you need. Contact your local bar association to find an attorney skilled in insurance litigation. If you need a bone marrow transplant, call the Blood and Bone Marrow Transplant Newsletter's attorney referral service at (847) 831-1913.

- Try to remember that many managed care organizations are used to passive consumers. Proactive, savvy HMO consumers can get excellent and comprehensive healthcare from an HMO if they choose wisely and have a good relationship with their doctor. Even when you are happy with your care, check the status of your HMO periodically because they are being bought, sold, and merged at a rapid rate. Make sure that economic forces have not changed the quality of the care provided by your plan.

This fact sheet was adapted from *Working with Your Doctor: Getting the Healthcare You Deserve* by Nancy Keene, . For more information, call **(800) 998-9938** or see *www.patient-centers.com*.