

Choosing and Using a Health Plan

Health care in America is changing rapidly. Twenty-five years ago, most people in the United States had indemnity insurance coverage. A person with indemnity insurance could go to any doctor, hospital, or other provider (which would bill for each service given), and the insurance and the patient would each pay part of the bill.

But today, more than half of all Americans who have health insurance are enrolled in some kind of managed care plan, an organized way of both providing services and paying for them. Different types of managed care plans work differently and include preferred provider organizations (PPOs), health maintenance organizations (HMOs), and point-of-service (POS) plans.

You've probably heard these terms before. But what do they mean, and what are the differences between them? And what do these differences mean to you?

Overview

This booklet can help you make sense of your choices for getting health care insurance:

Even if you don't get to choose the health plan yourself (for example, your employer may select the plan for your company), you still need to understand what kind of protection your health plan provides and what you will need to do to get the health care that you and your family need.

The more you learn, the more easily you'll be able to decide what fits your personal needs and budget.

Choosing a Plan

1. What Are My Health Plan Choices?

Choosing between health plans is not as easy as it once was. Although there is no one "best" plan, there are some plans that will be better than others for you and your family's health needs. Plans differ, both in how much you have to pay and how easy it is to get the services you need. Although no plan will pay for all the costs associated with your medical care, some plans will cover more than others.

Almost all plans today have ways to reduce unnecessary use of health care—and keep down the costs of health care, too. This may affect how easily you get the care you want, but should not affect how easily you get the care you need.

Plans change from year to year, so you should carefully consider each plan, using the questions outlined in this booklet. If you get health insurance where you work, you should start with your employee benefits office. Its staff should be able to tell you what is covered under the plans available. You can also call plans directly to ask questions.

Health insurance plans are usually described as either indemnity (fee-for-service) or managed care. These types of plans differ in important ways that are described below. With any health plan, however, there is a basic premium, which is how much you or your employer pay, usually monthly, to buy health insurance coverage. In addition, there are often other payments you must make, which will vary by plan. In considering any plan, you should try to figure out its total cost to you and your family, especially if someone in the family has a chronic or serious health condition.

Indemnity and managed care plans differ in their basic approach. Put broadly, the major differences concern choice of providers, out-of-pocket costs for covered services, and how bills are paid. Usually, indemnity plans offer more choice of doctors (including specialists, such as cardiologists and surgeons), hospitals, and other health care providers than managed care plans. Indemnity plans pay their share of the costs of a service only after they receive a bill.

Managed care plans have agreements with certain doctors, hospitals, and health care providers to give a range of services to plan members at reduced cost. In general, you will have less paperwork and lower out-of-pocket costs if you select a managed care type plan and a broader choice of health care providers if you select an indemnity-type plan.

Over time, the distinctions between these kinds of plans have begun to blur as health plans compete for your business. Some indemnity plans offer managed care-type options, and some managed care plans offer members the opportunity to use providers who are "outside" the plan. This makes it even more important for you to understand how your health plan works.

Besides indemnity plans, there are basically three types of managed care plans: PPOs, HMOs, and POS plans.

Indemnity Plan

With an indemnity plan (sometimes called fee-for-service), you can use any medical provider (such as a doctor and hospital). You or they send the bill to the insurance company, which pays part of it. Usually, you have a deductible—such as \$200—to pay each year before the insurer starts paying.

Once you meet the deductible, most indemnity plans pay a percentage of what they consider the "Usual and Customary" charge for covered services. The insurer generally pays 80 percent of the Usual and Customary costs and you pay the other 20 percent, which is known as coinsurance. If the provider charges more than the Usual and Customary rates, you will have to pay both the coinsurance and the difference.

The plan will pay for charges for medical tests and prescriptions as well as from doctors and hospitals. It may not pay for some preventive care, like checkups.

Managed Care

Preferred Provider Organization (PPO). A PPO is a form of managed care closest to an indemnity plan. A PPO has arrangements with doctors, hospitals, and other providers of care who have agreed to accept lower fees from the insurer for their services. As a result, your cost sharing should be lower than if you go outside the network. In addition to the PPO doctors making referrals, plan members can refer themselves to other doctors, including ones outside the plan.

If you go to a doctor within the PPO network, you will pay a copayment (a set amount you pay for certain services—say \$10 for a doctor or \$5 for a prescription). Your coinsurance will be based on lower charges for PPO members.

If you choose to go outside the network, you will have to meet the deductible and pay coinsurance based on higher charges. In addition, you may have to pay the difference between what the provider charges and what the plan will pay.

Health Maintenance Organization (HMO). HMOs are the oldest form of managed care plan. HMOs offer members a range of health benefits, including preventive care, for a set monthly fee. There are many kinds of HMOs. If doctors are employees of the health plan and you visit them at central medical offices or clinics, it is a staff or group model HMO. Other HMOs contract with physician groups or individual doctors who have private offices. These are called individual practice associations (IPAs) or networks.

HMOs will give you a list of doctors from which to choose a primary care doctor. This doctor coordinates your care, which means that generally you must contact him or her to be referred to a specialist.

With some HMOs, you will pay nothing when you visit doctors. With other HMOs there may be a copayment, like \$5 or \$10, for various services.

If you belong to an HMO, the plan only covers the cost of charges for doctors in that HMO. If you go outside the HMO, you will pay the bill. This is not the case with point-of-service plans.

Point-of-Service (POS) Plan. Many HMOs offer an indemnity-type option known as a POS plan. The primary care doctors in a POS plan usually make referrals to other providers in the plan. But in a POS plan, members can refer themselves outside the plan and still get some coverage.

If the doctor makes a referral out of the network, the plan pays all or most of the bill. If you refer yourself to a provider outside the network and the service is covered by the plan, you will have to pay coinsurance.

Primary Care Doctors

Your primary care doctor will serve as your regular doctor, managing your care and working with you to make most of the medical decisions about your care as a patient. In many plans, care by specialists is only paid for if you are referred by your primary care doctor.

An HMO or a POS plan will provide you with a list of doctors from which you will choose your primary care doctor (usually a family physician, internists, obstetrician-gynecologist, or pediatrician). This could mean you might have to choose a new primary care doctor if your current one does not belong to the plan.

PPOs allow members to use primary care doctors outside the PPO network (at a higher cost). Indemnity plans allow any doctor to be used.

2. Where Do I Get These Health Plans?

Group Policies

You may be able to get group health coverage—either indemnity or managed care—through your job or the job of a family member.

Many employers allow you to join or change health plans once a year during open enrollment. But once you choose a plan, you must keep it for a year. Discuss choices and limits with your employee benefits office.

Individual Policies

If you are self-employed or if your company does not offer group policies, you may need to buy individual health insurance. Individual policies cost more than group policies.

Some organizations—such as unions, professional associations, or social or civic groups—offer health plans for members. You may want to talk to an insurance broker, who can tell you more about the indemnity and managed care plans that are available for individuals. Some States also provide insurance for very small groups or the self-employed.

Medicare

Americans age 65 or older and people with certain disabilities can be covered under Medicare, a Federal health insurance program.

In many parts of the country, people covered under Medicare now have a choice between managed care and indemnity plans. They also can switch their plans for any reason. However, they must officially tell the plan or the local Social Security Office, and the change may not take effect for up to 30 days. Call your local Social Security office or the State office on aging to find out what is available in your area.

Medicaid

Medicaid covers some low-income people (especially children and pregnant women), and disabled people. Medicaid is a joint Federal-State health insurance program that is run by the States.

In some cases, States require people covered under Medicaid to join managed care plans. Insurance plans and State regulations differ, so check with your State Medicaid office to learn more.

Pre-Existing Conditions

A pre-existing condition is a medical condition diagnosed or treated before joining a new plan. In the past, health care given for a pre-existing condition often has not been covered for someone who joins a new plan until after a waiting period. However, a new law—called the Health Insurance Portability and Accountability Act—changes the rules.

Under the law, most of which goes into effect on July 1, 1997, a pre-existing condition will be covered without a waiting period when you join a new group plan if you have been insured the previous 12 months. This means that if you remain insured for 12 months or more, you will be able to go from one job to another, and your pre-existing condition will be covered—without additional waiting periods—even if you have a chronic illness.

If you have a pre-existing condition and have not been insured the previous 12 months before joining a new plan, the longest you will have to wait before you are covered for that condition is 12 months.

To find out how this new law affects you, check with either your employer benefits office or your health plan.

3. What Plan Benefits Are Offered?

Most plans provide basic medical coverage, but the details are what counts. The best plan for someone else may not be the best plan for you. For each plan you are considering, find out how it handles:

Physical exams and health screenings.

Care by specialists.

Hospitalization and emergency care.

Prescription drugs.

Vision care.

Dental services.

Also ask about:

Care and counseling for mental health.

Services for drug and alcohol abuse.

Obstetrical-gynecological care and family planning services.

Ongoing care for chronic (long-term) diseases, conditions, or disabilities.

Physical therapy and other rehabilitative care.

Home health, nursing home, and hospice care.

Chiropractic or alternative health care, such as acupuncture.

Experimental treatments.

Some plans offer members health education and preventive care, but services differ. Ask questions such as:

What preventive care is offered, such as shots for children?

What health screenings are given, such as breast exams and Pap smears for women?

Does the plan help people who want to quit smoking?

4. What Is Most Important to Me in a Plan?

In choosing a plan, you have to decide what is most important to you. All plans have tradeoffs. Ask yourself these questions:

How comprehensive do I want coverage of health care services to be?

How do I feel about limits on my choice of doctors or hospitals?

How do I feel about a primary care doctor referring me to specialists for additional care?

How convenient does my care need to be?

How important is the cost of services?

How much am I willing to spend on premiums and other health care costs?

How do I feel about keeping receipts and filing claims?

You might also want to think about whether the services a plan offers meet your needs. Call the plan for details about coverage if you have questions. Consider:

Life changes you may be thinking about, such as starting a family or retiring.

Chronic health conditions or disabilities that you or family members have.

If you or anyone in your family will need care for the elderly.

Care for family members who travel a lot, attend college, or spend time at two homes.

5. How Do I Compare Health Plans?

After you review what benefits are available and decide what is important to you, you can compare plans. Many things should be considered. These include services offered, choice of providers, location, and costs. The quality of care is also a factor to think about (see section 6.).

Services

Look at the services offered by each plan. What services are limited or not covered? Is there a good match between what is provided and what you think you will need? For example, if you have a chronic disease, is there a special program for that illness? Will the plan provide the medicines and equipment you may need? Find out what types of care or services the plan won't pay for. These usually are called exclusions.

Few indemnity and managed care plans cover treatments that are experimental. Ask how the plan decides what is or is not experimental. Find out what you can do if you disagree with a plan's decision on medical care or coverage.

Choice

What doctors, hospitals, and other medical providers are part of the plan? Are there enough of the kinds of doctors you want to see? Do you need to choose a primary care doctor? If you want to see a specialist, can you refer yourself or must your primary care doctor refer you? Do you need approval from the plan before going into the hospital or getting specialty care?

Location

Where will you go for care? Are these places near where you work or live? How does the plan handle care when you are away from home?

Costs

No health insurance plan will cover every expense. To get a true idea of what your costs will be under each plan, you need to look at how much you will pay for your premium and other costs.

Are there deductibles you must pay before the insurance begins to help cover your costs?

After you have met your deductible, what part of your costs are paid by the plan?

Does this amount vary by the type of service, doctor, or health facility used?

Are there copayments you must pay for certain services, such as doctor visits?

If you use doctors outside a plan's network, how much more will you pay to get care?

If a plan does not cover certain services or care that you think you will need, how much will you have to pay?

Are there any limits to how much you must pay in case of major illness?

Is there a limit on how much the plan will pay for your care in a year or over a lifetime? A single hospital stay for a serious condition could cost hundreds of thousands of dollars.

You can't know in advance what your health care needs for the coming year will be. But you can guess what services you and your family might need. Figure out what the total costs to your family would be for these services under each plan.

6. How Do I Find Out About Quality?

Quality is hard to measure, but more and more information is becoming available. There are certain things you can look for and questions you can ask. Whatever kind of plan you are considering, you can check out individual doctors and hospitals. For doctors, see "Tips on Choosing a Doctor."

Many managed care plans are regulated by Federal and State agencies. Indemnity plans are regulated by State insurance commissions. Your State Department of Health or insurance commission can tell you about any plan you are interested in.

You can also find out if the managed care plan you are interested in has been "accredited," meaning that it meets certain standards of independent organizations. Some States require accreditation if plans serve special groups, such as people in Medicaid. Some employers will only contract with plans that are accredited.

Several national organizations review and accredit plans and institutions. You can contact these organizations to see if a plan you are considering, or an institution in the plan, is accredited.

Another approach is to ask the plan how it ensures good medical care. Does the plan review the qualifications of doctors before they are added to the plan? Plans are supposed to review the care that is given by their doctors and hospitals. How does the plan review its own services, and has it made changes to correct problems? How does the plan resolve member complaints?

Some managed care plans survey members about their health care experiences. Ask the plan for a report of the survey results.

Some plans and independent organizations are also beginning to produce "report cards." These reports often include satisfaction survey results and other information on quality, such as if a plan provides preventive care (for example, shots for children and Pap smears for women) or if the plan follows up on test results. Report cards may also include information on how many members stay in or leave the plan, how many of the plan's doctors are board certified, or how long you may have to wait for an appointment.

Report cards can only give you an idea of how a plan works and may not give a full picture of a plan's quality. Ask plans if their activities have been reported in report cards developed by outside groups (business or consumer organizations).

Also keep any eye out for magazine articles that rate health plans.

Finally, you can talk to current members of the plan. Ask how they feel about their experiences, such as waiting times for appointments, the helpfulness of medical staff, the services offered, and the care received. If there are programs for your particular condition, how are the patients in it doing?

Tips on Choosing a Doctor

Your doctor will be your partner in care, so it is important to choose carefully from the doctors available to you. In some managed care plans, you will generally be limited to choosing from only certain doctors; in other plans, some doctors may be "preferred," which means they are part of a network and you will pay less if you use them. Ask your plan for a list or directory of providers. The plan may also offer other help in choosing. You can ask doctors you know, medical societies, friends, family, and coworkers to recommend doctors. You may also contact hospitals and referral services about doctors in your area.

Once you have the names of doctors who interest you, make sure they are accepting new patients. Here's how to check doctors out:

Ask plans and medical offices for information on their doctors' training and experience.

Look up basic information about doctors in the Directory of Medical Specialists, available at your local library. This reference has up-to-date professional and biographic information on about 400,000 practicing physicians.

Use "AMA Physician Select," which is the American Medical Association's free service on the Internet for information about physicians (<http://www.ama-assn.org/aps/amahg.htm>).

You may also want to find out:

Is the doctor board certified? Although all doctors must be licensed to practice medicine, some also are board certified. This means the doctor has completed several years of training in a specialty and passed an exam. Call the American Board of Medical Specialties at 800-776-2378 for more information.

Have complaints been registered or disciplinary actions taken against the doctor? To find out, call your State Medical Licensing Board. Ask Directory Assistance for the phone number.

Have complaints been registered with your State department of insurance? (Not all departments of insurance accept complaints.) Ask Directory Assistance for the phone number.

Once you have narrowed your search to a few doctors, you may want to set up "get acquainted" appointments with them. Ask what charge there might be for these visits, if any. Such appointments give you a chance to interview the doctors—for example, to find out if they have much experience with any health conditions you may have.

Using Care

7. How Can I Get the Most from My Plan?

You will get the best care if you:

Stay Informed

Read your health insurance policy and member handbook. Make sure you understand them, especially the information on benefits, coverage, and limits. Sales materials or plan summaries cannot give you the full picture.

See if your plan has a magazine or newsletter. It can be a good source of information on how the plan works and on important policies that affect your care.

Talk to your health benefits officer at work to learn more about your policy.

Ask how the plan will notify you of changes in the network of providers or covered services while you are part of the plan.

Take Charge

Ask your doctor about regular screenings to check your health. Discuss your risk of getting certain conditions. What lifestyle choices and changes might you need to make to lower your risks or prevent illness?

Ask questions and insist on clear answers.

Ask about the risks and benefits of tests and treatments. Tell your doctor what you like and dislike about your choices for care.

Make sure you understand and can follow the doctor's instructions. You may want to bring another person along or take notes to help you remember things.

Keep Track

Write down your concerns. Start a health log of symptoms to help you better explain any health problems when you meet with your doctor.

Set up health files for family members at home. This will help you to monitor care. Include health histories of shots, illnesses, treatments, and hospital visits. Ask for copies of lab results. Keep a list of your medicines, noting side effects and other problems (such as other drugs and foods that should not be taken at the same time).

8. How Do I Obtain Care?

Learning what you can expect from your health plan and how it works are key steps to getting the care you need. Ask these questions:

When are the offices open? What if I need care after hours?

How do I make appointments? How quickly can I expect to be seen for illness or for routine care?

If I need lab tests, are they done in the doctor's office or will I be sent to a laboratory?

Will most of my appointments be with the primary care doctor? Will nurse practitioners or physician's assistants sometimes give care as well?

Is there an advice hotline? Some plans have toll-free phone services that help members decide how to handle a problem that may not require a doctor's visit.

Find out how your plan provides care outside the service area and what you must do to get care. This is especially important if you travel often, are away from home for long periods, or have family members away at school.

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9. What if I Have to Go to the Hospital?

The time to find out what rules your plan has on hospital care is before you need it.

Planned Hospitalizations

Unless it is a medical emergency, your health plan or primary care doctor will probably have to give advance approval (preadmission certification) for you to go to the hospital. Otherwise, the cost of your hospital care may not be covered. Ask these questions:

What hospitals are part of the plan network?

Is there a limit on how long I can stay in the hospital?

Who decides when I am to be discharged?

Will needed followup care, such as nursing home or home health care, be covered by the plan?

If I have a serious medical problem, will the plan provide someone to oversee care and make sure my needs are met?

Ask how your plan handles getting a second doctor's opinion on whether surgery or another treatment is needed. Are second opinions encouraged or required? Who pays?

Emergency or Urgent Care

If you have a true medical emergency, you should go to the nearest hospital as fast as possible. It is important for you to know what kind of medical problems are defined as emergencies and how to arrange for ambulance service, if needed. Most plans must be told within a certain time after emergency admission to a hospital. If the hospital is not part of the plan network, you may be transferred to a network hospital when your condition is stable. Ask these questions:

How does the plan define "emergency care?" What conditions or injuries are considered emergencies?

How does the plan handle "urgent care" after normal business hours? Urgent care is for problems that are not true emergencies but still need quick medical attention. Check with your plan to find out what it considers to be urgent care. Examples may include sore throats with fever, ear infections, and serious sprains. Call your primary care doctor or the plan's hotline for advice about what to do. The plan may also have urgent care centers for members.

How do I get urgent care or hospital care if I am out of the area? How must I tell the plan and how soon after I get the care?

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10. What if I Am Not Satisfied with My Care?

Getting the best care and services means understanding how your health plan works, what your rights are, and how to complain if you need to. You have the right to get copies of test results as well as medical information about yourself. If you are in a managed care plan, you can ask to change your primary care doctor if you are unhappy with the relationship. You may also be able to switch plans during open enrollment.

Most plans have an appeals process that both you and your doctor may use if you disagree with the plan's decisions. If your plan refuses to provide or pay for services, you can complain or file a grievance about any decision you feel is unfair—or you can appeal it.

You can contact the member services division of your plan for more information or to complain. Use your plan's complaint process fully before taking other action.

Be sure to keep written records of:

All correspondence with the plan.

Claims forms and copies of bills.

Phone conversations—the date and time, the people you speak with, and the nature of each call.

If the plan does not satisfy you, you may decide to bring the matter to the attention of your employee benefits manager, your State insurance commissioner, your State department of health, or the legal system. If you are a Medicare or Medicaid beneficiary, you have additional ways through those programs to file a grievance about the care received from a plan or provider. For information, contact your State's medical Peer Review Organization or State Medicaid Program.

Sources of Additional Information

Many organizations have information that can help you understand your health care choices. Some helpful materials and contacts are listed.

General Information

"Checkup on Health Insurance Choices"

"Questions To Ask Your Doctor Before You Have Surgery"

Agency for Health Care Policy and Research

Publications Clearinghouse

P.O. Box 8547

Silver Spring, MD 20907

800-358-9295

"The Consumers Guide to Health Insurance"

Health Insurance Association of America

555 13th St. N.W., 600 East

Washington, DC 20004-1109
(202) 824-1600

"Guide to Health Insurance for People with Medicare"

"Your Medicare Handbook"

"Managed Care Plans"

Health Care Financing Administration

7500 Security Blvd.

Baltimore, MD 21244-1850

800-638-6833

"Putting Patients First"

National Health Council

1730 M St., NW, Suite 500

Washington, DC 20036-4505

(202) 785-3910

"Managed Care: An AARP Guide"

American Association of Retired Persons

611 E St., N.W.

Washington, DC 20049

(202) 434-2277

"Choosing Quality: Finding the Health Plan That's Right for You"

National Committee for Quality Assurance

2000 L St., N.W., Suite 500

Washington, DC 20036

800-839-6487

"Consumers' Guide to Health Plans"

Consumers' Checkbook

Center for the Study of Services

733 15th St., N.W., Suite 820

Washington, DC 20005

(202) 347-7283

Accreditation and Quality

Accreditation Association for Ambulatory Health Care; 9933 Lawler Ave.; Skokie, IL 60077-3708; (847) 676-9610

Accredits outpatient health care settings such as ambulatory surgery centers, radiation oncology centers, and student health centers. Call for a list of accredited organizations.

Community Health Accreditation Program; 350 Hudson St.; New York, NY 10014; 800-669-1656, ext. 242

Accredits community, home health, and hospice programs; public health departments; and nursing centers. Call for a list of accredited organizations.

Consumer Coalition for Quality Health Care; 1275 K Street, N.W.; Suite 602; Washington, DC 20005; (202) 789-3606

A national, nonprofit organization of consumer groups advocating for consumer protections and quality assurance programs and policies. Call with general questions about quality issues or for consumer materials on managed care and activities at the State level.

Joint Commission on Accreditation of Healthcare Organizations; One Renaissance Blvd.; Oakbrook Terrace, IL 60181; (630) 792-5000

Evaluates and accredits nearly 20,000 health care organizations and programs including almost 12,000 hospitals and home care organizations, and more than 7,000 other health care organizations that provide long term care, behavioral health care, laboratory and ambulatory care services. The Joint Commission also accredits health plans, integrated delivery networks, and other managed care entities. Visit Quality Check on the Joint Commission's Web site (<http://www.jcaho.org>) for information on individual accredited organizations or for general information about assessing the quality of health care organizations.

National Committee for Quality Assurance; 2000 L St. N.W., Suite 500; Washington, DC 20036; 800-839-6487; Web Site: <http://www.ncqa.org>

Accredits HMOs and other managed care organizations. Call for the NCQA Accreditation Status List, Accreditation Summary Report, publications list, or for general information about quality.

Utilization Review Accreditation Commission; 1130 Connecticut Ave. N.W., Suite 450; Washington, DC 20036; (202) 296-0120

Accredits PPOs and other managed care networks. Call for a list of accredited organizations.

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This consumer's guide was developed by the Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Rockville, MD, in cooperation with the Health Insurance Association of America, Washington, DC.

AHCPR Publication No. 97-0011
Current as of March 1997

Internet Citation:

Choosing and Using a Health Plan. AHCPR Publication No. 97-0011, March 1997. Agency for Health Care Policy and Research, Rockville, MD, and the Health Insurance Association of America, Washington, DC.
<http://www.ahrq.gov/consumer/hlthpln1.htm>