SELECTING A HEALTH PLAN

Choosing between health plans is no longer a simple matter. As a healthcare consumer, it's important that you educate yourself about the various health plans available to you. You'll want to consider the costs, benefits, ease of obtaining medical services, and how well the plan matches the needs of you and your family. This guide will help you increase your knowledge, set priorities for what you need most, and ultimately select a health plan that will help to ensure that you receive quality health care.

Step 1: Gather Basic Information

A variety of health insurance plans exist today, from traditional "fee-for-service" to managed care options. Here are definitions for the most common health plans:

- **Traditional Health Insurance**: Also known as "indemnity" or "fee-for-service" insurance; you choose your doctor and hospital, and you or the provider sends the bill to the insurance company. You pay an annual deductible after which the insurance company generally pays 80% of the "usual and customary" charges and you pay 20%, your coinsurance. You are also responsible for any amount not covered by your insurance. This option allows for greater freedom in choosing providers, but you will generally pay more out of your own pocket.
- **Managed Care Options**: Managed care plans were designed to help control the cost of health care services, while ideally improving quality as well. Your choices are generally more limited than in a traditional plan, but you're likely to have lower out-of-pocket costs. The following plans represent a sampling of managed care options:
  - **Health Maintenance Organization (HMO)**: You choose a primary care physician (PCP) who will provide routine care and coordinate specialty referrals. You must use providers who are within the HMO's network and get a referral from you PCP for other medical services. You may have co-pays ($5-$25) for covered services, but usually pay nothing else as long as you receive care from network providers.
    - **Individual Practice Association (IPA)**: Consists of a group of physicians or other providers who contract with an HMO to provide medical services. Some HMO's require you to choose an IPA, as well as a PCP. If this is the case, it is important to remember that your selection of hospitals and specialists is often limited to those providers that contract with the particular IPA.
  - **Preferred Provider Organization (PPO)**: You choose physicians and hospitals from a network that has agreed to accept discounted rates for services. You may also see physicians outside the network, but at a higher cost.
  - **Point-of-Service Plan (POS)**: Also known as an "open-ended" HMO, this type of plan enables you to choose network or non-network providers for medical services. You'll pay higher deductibles and copayments if you use non-network providers.
  - **Exclusive Provider Organization (EPO)**: You receive care from a network of providers that have agreed to provide services on a discounted basis. You typically don't need to receive referrals to obtain care within the network, but if you see a provider outside of the network, you will not be reimbursed for the cost.
  - **High Deductible or Catastrophic Plan**: This health plan covers major medical expenses after you pay the yearly deductible. You typically do not receive coverage for preventive services, such as physical examinations, and you generally have higher deductibles. This type of plan may be combined with a Medical Savings Account.

Step 2: Assess Your Needs

To help narrow your search for the health plan that best matches your needs, take a look at your current use of healthcare, anticipated medical expenses, and what services are most important to you and your family. Ask yourself the following questions to help you evaluate your current situation:

- Do you want to continue your relationship with your current primary care physician? Is he/she part of your new health plan?
- Do you want the flexibility of seeing out-of-network providers?
- Do you use healthcare services frequently, e.g. for a chronic disease?

- Do you have children who require preventive care, such as immunizations or frequent physician or emergency room visits for accidents?
- Does your spouse have a benefit plan? If so, are you and your dependents covered under this plan?
- How much can you afford to pay for monthly premiums? **Keep in mind that a lower monthly premium doesn't necessarily save you money. Make sure you thoroughly evaluate your potential out-of-pocket expenses.**
- Do you anticipate hospital stays, e.g. pregnancy? Could you afford the coinsurance rate if you had an unexpected hospitalization?
- Are you currently being treated for a medical condition? Will the plan cover treatment immediately or is there a waiting period?
- Do you travel frequently? Will the health plan cover medical expenses if you are out of the area?
- Would you prefer to receive care at a particular hospital? Is it part of the plan's network? If you signed up for an IPA, is it in their network?

Step 3: Compare Plans

Although it may be difficult to find one health plan that offers exactly what you need, you'll benefit from taking a closer look at your options and making a list of pros and cons for each plan. You'll want to compare the plan's benefits, access, costs, convenience, customer service, and quality, and then decide which plan best fits your healthcare needs.

- **Benefits/Coverage**
  - Have you reviewed the plan's written description of its benefits and covered services? (Evidence of Coverage or Summary Plan Description)
  - Does the plan cover preventive care, such as physical exams and immunizations?
  - If you travel, will the plan cover your medical expenses?
  - Is there a maximum amount that the plan will pay on an annual and/or lifetime basis?
  - Will your child be covered as a dependent, up to what age?
  - Are hospital stays limited to a certain number of days for each illness?
  - What coverage is available for rehabilitation therapy (physical, speech, or occupational)?
  - Will your prescriptions be covered and does the plan have a Formulary? If you have a chronic condition, is your medication on the Formulary?
  - Will you receive coverage for eye and dental exams?
  - Does the plan cover complementary care, like chiropractic and acupuncture?
  - Will mental health treatment be covered, and for how long?
  - What are the plan's guidelines for covering experimental treatment and clinical trials?
  - What other medical services, such as nursing home care or drug/alcohol treatment, are important to you and your family? Does the plan provide coverage?

- **Access**
  - Are the doctors and specialists who currently treat you a part of this plan? Are they accepting new patients for this plan?
  - Do you need a referral to see a specialist? What is the average wait time to see a specialist? If you have a chronic disease, how long will the referral last?
  - Will you be allowed to change your doctor if you are unhappy with him/her?
  - What hospitals and clinics can you use with the plan?
  - How long will you need to wait for medical appointments? Are the hours convenient?
  - How does the plan handle urgent care after normal business hours?
  - If you require emergency room treatment, what are the plan's procedures for getting it approved?

- **Costs**
  - What will you need to pay for monthly premiums?

  - What are the plan's deductible, copay, and coinsurance rates?
  - Will you need to pay more if you see an out-of-network provider?

- **Convenience**
  - Do you have to file claim forms?
  - Are doctors, hospitals, and pharmacies near your home?
  - How often can you change doctors?
  - Does the plan offer a telephone nurse advice line?

- **Customer Service**
  - Does the plan survey its members to determine how satisfied they are with the services? If so, can you get this information from customer service, and what percentage of members is satisfied with their care?
  - Is there an 800 number you can call for questions and assistance with health plan issues? Test it out before selecting a health plan.

- **Quality**
  - Is a fair and open appeals process available if the plan denies treatment? Does the plan use an external, independent agency to review appeals?
  - What is the turnover rate among doctors in the plan?
  - Does the plan share data on member disenrollment?
  - Does the plan keep data on members' health outcomes that it's willing to share? (sometimes known as "HEDIS" data)
  - Is the plan accredited by the National Council for Quality Assurance (NCQA)? You can look this up on their website at http://www.ncqa.org.
  - Check out "report cards" which compare plan performance, satisfaction survey results, and disenrollment data. A good source for this type of comparative data is at http://www.healthgrades.com.
  - If you do not have internet access or need extra assistance researching health plans, please contact CareCounsel.

Step 4 Ask for Recommendations

- Ask your PCP to comment on the plan's:
  - Ease of specialty referrals and availability of specialists
  - Hospitals, formulary, preventive care
  - Claims and Utilization Review process
- Ask family and friends for recommendations, especially if they are healthcare professionals.
- Talk over any questions or concerns with a CareCounselor.

Step 5 Make Your Choice

The health plan you select must be the one that best matches your needs and priorities. It's important that your decision be based on complete information. Be sure to read all available health plan materials and contact the health plan representative or CareCounsel if you still have unanswered questions. Once you understand and compare the different health plan options, you can pick the one that best fits the needs of you and your family.

Health Plan Selection Check List

	PLAN A	PLAN B	PLAN C
Plan Name			

BENEFITS

Does the plan have a formulary? If you have a chronic condition, is your medication on the formulary?			
Does the plan cover preventive care, such as physical exams and immunizations?			
If you travel, will the plan cover your medical expenses?			
Will mental health/substance abuse treatment be covered, and for how long?			
Is there a maximum amount that the plan will pay on an annual and/or lifetime basis?			
Up to what age will your child be covered as a dependent?			

ACCESS AND CONVENIENCE

How long will you need to wait for medical appointments? Are the hours convenient? (contact providers office)			
Will you be allowed to change your doctor if you are unhappy with him/her? How often can you make a change?			
Do you need a referral to see a specialist? How do you obtain the referral? How long is the referral good for?			
How does the plan handle urgent care after normal business hours?			
If you require emergency room treatment, what are the plan's procedures for getting it approved?			

	PLAN A	PLAN B	PLAN C
Plan Name			

CHOICE OF PROVIDERS

Are the doctors and specialists who currently treat you a part of this plan? Are they accepting new patients for this plan?			
Are you limited to using providers within a specific medical group or IPA?			
Does the plan have an out-of-network option?			
What hospitals and clinics can you use with the plan?			

COST

What will you need to pay for monthly premiums?			
What are the plan's deductible, copay, and coinsurance rates?			
Is the cost of seeing an out-of-network provider reasonable?			
Is there a maximum limit on out-of-pocket costs per year? How much?			

QUALITY

Compare quality and satisfaction ratings at http://www.healthgrades.com.			
Is the plan accredited by the National Council for Quality Assurance (NCQA)?			
Does the plan have an external review process?			

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For more information, contact CareCounsel at 1-888-227-3334.